Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498
Project Name/Number: 10498/10498

Filing at a Glance

Company: American National Insurance Company

Product Name: 10498 SERFF Tr Num: AMNA-127992033 State: Arkansas TOI: L08 Life - Other SERFF Status: Closed-Approved-State Tr Num:

Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: 10498 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Authors: Tyra Reed, Amber Adams, Disposition Date: 02/09/2012

Tobie Brink

Date Submitted: 02/06/2012 Disposition Status: Approved-

Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

General Information

Project Name: 10498 Status of Filing in Domicile: Pending

Project Number: 10498

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Submission Type: New Submission Individual Market Type:

Overall Rate Impact: Filing Status Changed: 02/09/2012
State Status Changed: 02/09/2012

Deemer Date: Created By: Tobie Brink

Submitted By: Tobie Brink Corresponding Filing Tracking Number:

Filing Description: January 31, 2012

Arkansas Insurance Department Compliance ©\ Life and Health 1200 West Third Street

Little Rock AR 72201©\1904

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:

10498-AR- Application for Individual Life Insurance

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498

Project Name/Number: 10498/10498

SERFF Tracking Number: AMNA- 127992033

Company Tracking Number: 10498

Dear Reviewer:

Please find attached the above listed form for your department; s review and approval. This form is a new form and will not replace any previously approved forms.

10498-AR is a simplified issue life application. The recognized market where the application will be used is: direct mail and bank market. The application will be used to apply for previously approved individual simplified issue term life and whole life products. Currently, the application will be used to apply for the following policies:

Form LCT09DM(10) "C approved 1/11/2010 SERFF Tracking Number AMNA-126425223 Form LNCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223 Form RCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223 Form NPWL09DM(10) "C approved 2/17/2010 SERFF Tracking Number AMNA-126484400

Within the application_i and Agreements section, the applicant is asked to acknowledge their receipt of the Exchange of Information Notice, which contains Medical Information Bureau (MIB, Inc.) and Fair Credit Report Act (FCRA) information. This notice is provided as a part of the solicitation materials and is read when the application is taken online/telephone. A copy is left with the applicant.

Additional information/supporting documentation included in this submission is as follows:

- -Statement of Variability
- -Payment of the required filing fees have been submitted via EFT
- -Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Sincerely,

Tobie Brink Life Policy Analyst III

Company and Contact

Filing Contact Information

Tobie Brink, Project Coordinator Tobie.Brink@ANICO.com

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498

Project Name/Number: 10498/10498

One Moody Plaza 409-763-1112 [Phone] 4165 [Ext]

Actuarial Product Development 409-766-6933 [FAX]

14th Floor

Galveston, TX 77550

Filing Company Information

American National Insurance Company CoCode: 60739 State of Domicile: Texas

One Moody Plaza Group Code: 408 Company Type:
Galveston, TX 77550 Group Name: State ID Number:

(409) 763-4661 ext. [Phone] FEIN Number: 74-0484030

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes

Fee Explanation: 1 form - exempt, no policy present @ 50 per form.

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

American National Insurance Company \$50.00 02/06/2012 56100381

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498

Project Name/Number: 10498/10498

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	02/09/2012	02/09/2012

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498

Project Name/Number: 10498/10498

Disposition

Disposition Date: 02/09/2012

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498

Project Name/Number: 10498/10498

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Cover Letter		No
Supporting Document	Statement of Variability		No
Supporting Document	Online Screen Prints		No
Supporting Document	Telephone Screen Prints		No
Supporting Document	Process Summary		No
Form	Application for Life Insurance		No

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498

Project Name/Number: 10498/10498

Form Schedule

Lead Form Number:

Schedule Form Form Type Form Name Action Action Specific Readability Attachment

Item Number Data

Status

10498-AR Application/Application for Life Enrollment Insurance Form

Form Type Form Name Action Action Specific Readability Attachment

Data

50.200 10498-AR.pdf



Application For Individual Life Insurance

American National Insurance Company [P.O. Box 696700 San Antonio, TX 78269]

Your Details:	Your Spouse's Details (if applying):
Name:	Name:
Address: Apt	Address: Apt
City: State: Zip Code:	City: State: Zip Code:
Phone #1: ()Phone #2: ()	Phone #1: () Phone #2: ()
E-mail:	E-mail:
Social Security Number:	Social Security Number:
Date of Birth:/	Date of Birth:/
Female Male Height: ft. in. Weight:	Female Male Height: ft. in. Weight:
Are you a U.S. Citizen? Yes No If 'No', do you have a permanent residence status? Yes No	Are you a U.S. Citizen? Yes No If 'No', do you have a permanent residence status? Yes No
Annual Household Income: Under \$10,000 \ \$10,000 - \$24,999 \ \$25,000 - \$49,999 \ \$50,000 - \$99,999 \ \$100,000+	Annual Household Income: Under \$10,000 \ \$10,000 - \$24,999 \ \$25,000 - \$49,999 \ \$50,000 - \$99,999 \ \$100,000+
Marital Status: Single Married	Marital Status: Single Married
Have you smoked cigarettes in the last 12 months? Yes No	Have you smoked cigarettes in the last 12 months? Yes No
Occupation:	Occupation:
Your Amount of Coverage & Beneficiary:	Your Spouse's Coverage & Beneficiary:
Plan:	Plan:
Amount (choose one):	Amount (choose one):
Amount (choose one): [\$250,000	
Amount (choose one): [\$250,000	Amount (choose one): [
Amount (choose one): [Amount (choose one): [
Amount (choose one): [Amount (choose one): [
Amount (choose one): [Amount (choose one): [
Amount (choose one): [Amount (choose one): [
Amount (choose one): [Amount (choose one): [
Amount (choose one): [Amount (choose one): [

continued on back...

Your Health:	Your Spouse's Health (if applying):
	member of the medical profession for a seizure or transient ischemic gnosed or treated by a member of the medical profession or received se, convicted of driving while intoxicated (DWI) or driving under the Your Spouse Yes No
3. Are you currently admitted to or confined to a hospital, mental instruction care or need assistance with eating, bathing or dressing? You Yes No	itution, nursing home, assisted living center or receiving home health Your Spouse Yes No
	ling disorder, anemia or blood disease, diabetes treated with insulin or medications or hospitalization? If "Yes", provide details below (dates of
5. Within the past 60 days, have you been advised by a member of the been completed or are still awaiting results, such as any hospitaliza Immunodeficiency Virus (AIDS virus)? If "Yes", provide details be You Yes No Details:	tion, surgery or diagnostic test, except those tests related to the Human
If you have more details, please inclu	de them on a separate sheet of paper
Your Payment — choose one:	
Γ	
I/we authorize the collection of premiums for the policy or policies as	s follows.
I/we authorize the collection of premiums for the policy or policies as [1. Automatic monthly deductions from my checking or savings as	
[1. Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a contract of the c	deposit slip when providing savings account.)
[1. Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a classical Charge monthly premiums to my: Visa MasterCard	leposit slip when providing savings account.) Discover // // // // // // // // // // // // //
[1. Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a classical Charge monthly premiums to my: Visa MasterCard	deposit slip when providing savings account.)
[1. Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a contract of the c	deposit slip when providing savings account.) Discover (Account Number) (Exp. Date)
[1. Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a complete of the c	deposit slip when providing savings account.) Discover (Account Number) (Exp. Date)
[1. Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a complete and the company and a complete and a	Discover (Account Number) (Exp. Date) ase and Disclose Medical Information: I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address. •[I have read the Consumer Disclosure on the Sale of Insurance accompanying this application.] • I acknowledge receiving the Exchange of Information Notice. • Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498
Project Name/Number: 10498/10498

Supporting Document Schedules

Item Status: Status

Date:

Satisfied - Item: Flesch Certification

Comments: Attachments:

AR Readability Certification.pdf

AR - Certification of Compliance.pdf

Item Status: Status

Date:

Bypassed - Item: Application

Bypass Reason: This is not a product/policy form filing.

Comments:

Item Status: Status

Date:

Satisfied - Item: Cover Letter

Comments:
Attachment:
AR.pdf

Item Status: Status

Date:

Satisfied - Item: Statement of Variability

Comments: Attachment:

AR Statement of Variability.pdf

Item Status: Status

Date:

Satisfied - Item: Online Screen Prints

Comments:

Filing Company: American National Insurance Company State Tracking Number:

Company Tracking Number: 10498

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: 10498

Project Name/Number: 10498/10498

Attachment:

AR screen shots-customer.pdf

Item Status: Status

Date:

Satisfied - Item: Telephone Screen Prints

Comments:

Attachment:

AR screen shots-call center.pdf

Item Status: Status

Date:

Satisfied - Item: Process Summary

Comments: Attachment:

ANICO Direct Process.pdf



READABILITY CERTIFICATION

We hereby certify that the following form(s), meet the requirements of the Readability Insurance Policies Act:

Form	Form Name	Scoring(s)
10498-AR	Application for Individual Life Insurance	50.2

Ruy D. Henre

Rex D. Hemme

Senior Vice President & Actuary

American National Insurance Company

1/26/2012



CERTIFICATION OF COMPLIANCE

The Company has reviewed the captioned form(s) below, and certifies that to the best of its knowledge and belief, the form(s) submitted is (are) in compliance with the following:

Rule & Regulation 19 Rule & Regulation 49 ACA 23-79-138 and Bulletin 15-2009 ACA 23-80-206 (Flesch Certification, minimum of 40)

<u>Form</u>	Form Name	Scoring(s)
10498-AR	Application for Life Insurance	50.2

Rex D. Hemme

Senior Vice President & Actuary

Ruy D. Han

American National Insurance Company



Tobie Brink, Life Policy Analyst III Product Development – Actuarial Home Office : One Moody Plaza, 14th Floor Galveston, Texas 77550 e-mail: tobie.brink@ANICO.com Phone: (409) 763-4661 x 4265 Fax: (409) 766-6522

January 31, 2012

Arkansas Insurance Department Compliance - Life and Health 1200 West Third Street Little Rock AR 72201-1904

RE: American National Insurance Company (NAIC: 60739 FEIN: 74-0484030) Filing Of:

10498-AR- Application for Individual Life Insurance

SERFF Tracking Number: AMNA- 127992033

Company Tracking Number: 10498

Dear Reviewer:

Please find attached the above listed form for your department's review and approval. This form is a new form and will not replace any previously approved forms.

10498-AR is a simplified issue life application. The recognized market where the application will be used is: direct mail and bank market. The application will be used to apply for previously approved individual simplified issue term life and whole life products. Currently, the application will be used to apply for the following policies:

Form LCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223 Form LNCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223 Form RCT09DM(10) - approved 1/11/2010 SERFF Tracking Number AMNA-126425223 Form NPWL09DM(10) - approved 2/17/2010 SERFF Tracking Number AMNA-126484400

Within the application's Authorization to Obtain, Release and Disclose Medical Information and Agreements section, the applicant is asked to acknowledge their receipt of the Exchange of Information Notice, which contains Medical Information Bureau (MIB, Inc.) and Fair Credit Report Act (FCRA) information. This notice is provided as a part of the solicitation materials and is read when the application is taken online/telephone. A copy is left with the applicant.

Additional information/supporting documentation included in this submission is as follows:

- Statement of Variability
- Payment of the required filing fees have been submitted via EFT
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing.

Sincerely,

TobleBrink

Tobie Brink Life Policy Analyst III

Statements of Variability

Direct Response Application

10498-AR

Variable fields are as follow. Any state/entity specific deviations or exceptions are included.

Company Address – The application provides an address (Street and/or P O Box, City, State, and ZIP Code) for the company to which the completed application may be mailed. The address for the company is filed as variable material to allow for updates. The address provided will coincide with the appropriate receiving department. Potential alternatives, if any, will need to be provided.

i.e. San Antonio; League City

Amount – Based on the product solicited, the three most popular applied for face amounts (based on experience) will be pre-filled as possible selections. A reasonable range for the displayed amounts would be a minimum of \$2,000 and a maximum of \$250,000. The applicant is able to choose an amount other than those shown on the application by selecting the "Other" box and filling in the desired dollar amount.

Automatic Premium Loan Provision Requested – The check box to elect the Automatic Premium Loan Provision ("APL") is only applicable to Whole Life products. When the product solicited is a Term product or a Whole Life product that does not offer APL, the "No" check box will be pre-filled. When the product solicited is a Whole Life product that offers APL, both check boxes will be open, allowing the applicant to choose.

Payment Selection – This section will be pre-filled with payment options that vary based on the market. For markets where an inherent payment vehicle is available (relationships with banks, credit card issuers, mortgages, etc...), such financial institution may have preferred language that we are required to use. However, all language will involve the authorization of premium payments to be automatically charged/deducted from the prospective insureds account.

Examples of the basic types of text that will appear are as follows:

For broad market solicitations:

1.	\square Automatic monthly deductions from	n my checking or savings account
	(Enclose a voided check or a deposit sl	p for the account to be charged.
2.	☐ Charge monthly premiums to my: ☐] Visa □ MasterCard □ Discover
	(Account Number)	(Exp. Date)
3.	Bill me/us. (Send no money now.)	

For bank solicitations: I understand that by signing this application I authorize my premiums to be automatically deducted from my [name of bank] account once the policy is issued. All premiums for this coverage will be automatically deducted monthly from my account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically charged to my [name of bank] checking account once the policy is issued. All premium payments for this coverage will be automatically charged monthly to my checking account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically debited from my [name of bank] checking account once the policy issued. All premium payments for this coverage will be debited monthly from my [name of bank] checking account until I instruct otherwise.

For credit card solicitations: I understand that by signing this application I authorize my premiums to be automatically charged to my (name of bank) account once the policy is issued. All premiums for this coverage will be automatically charged monthly to my account, subject to credit approval, until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically charged to my (name of bank) credit card account once the policy is issued. All premium payments for this coverage will be automatically charged monthly to my credit card account until I instruct otherwise.

I understand that by signing this application I authorize my premium payments to be automatically debited from my [name of bank] credit card account once the policy issued. All premium payments for this coverage will be debited monthly from my [name of bank] credit card account until I instruct otherwise.

For Mortgage Solicitations: I understand that by signing this application I hereby certify that I have the authority and do so authorize (name of Mortgage Lender) to add my life insurance premium payments to my mortgage payment.

I understand that by signing this application I hereby certify that I have the authority and do so authorize (name of Mortgage Lender) to add my life insurance premium payments to my mortgage payment.

I understand that by signing this application I authorize (name of Mortgage Lender) to bill and collect premium with my mortgage payment.

The above does not represent every possible scenario but serves as examples.

For solicitations where a billing mechanism is not inherent in the marketing, the following options or some combination of the options would be provided:

- 1. Automatic monthly deductions from my checking or savings account. (Enclose a number deposit slip or voided check.)
- 2. Charge monthly premiums to my: (checkboxes for each) Visa, MasterCard, Discover (and fields for credit card number and expiration date).
- 3. Bill me. (Send no money now.)
- 4. Check Enclosed for my first premium
- 5. Payment attached for my first premium

CONSUMER DISCLOSURE STATEMENT – Within the Agreements section, the last statement: "I have read the Consumer Disclosure on the Sale of Insurance accompanying this application." will only appear for those applications produced for the Bank Solicitation channel. The Consumer Disclosure on the Sale of Insurance is contained on the accompanying letter that is provided with the application when the product is solicited via banks and states the following:

- -Not Insured by FDIC
- -Not a Deposit of or Guaranteed by (Bank Name) or any Federal Government Agency or any (Bank Name) Affiliates.

We certify that any change or modification to a variable item will be administered in accordance with the requirements in the Variability of Information section from the applicable product standards, including any requirements for prior approval of a change or modification.





ABOUT US | FAQS | PRIVACY | CONTACT US





Apply Your Information First Name: * Middle Initial: Last Name: * Mailing Address: * City: * State: * ZIP: * Gender: * Date of Birth: * Male © Female Phone #1: * Phone #2: Phone #2: Have you smoked cigarettes in the last 12 months? * Yes © No Social Security Number: * Occupation: * Annual Household Income: * Select One * Coose Your Beneficiary Deneficiary survives the owner, or none is named, payment will be made to the owner's estate. Middle Initial: Last Name: Middle Initial: Last Name:	TEP-2: Apply For Instant Cov asterisked *fields must be completed.	/erage	You are 20% complete
Annual Household Income: Middle Initiat Last Name:	ce your coverage depends on the i	information you provide on you	r application, it is vitally important that you answer each
Annual Household Income: Middle Initiat Last Name:	upply Your Information		
City: State: ZP: Date of Birth: Mate	First Name: *	Middle Initial:	Last Name: *
City: State: ZP: Date of Birth: Mate			
City: State: ZP: Date of Birth: Mate	Primary Mailing Address: *		
Gender: Male Female Phone #1: Phone #1: Phone #2: Email Address: Coverage Amount: Have you smoked cigarettes in the last 12 months? Yes No Social Security Number: It in bs J.S. Citizen: Marital Status: Select One Marital Status: Select One Middle Initial: Last Name: Middle Initial: Last Name: Middle Initial: Last Name: Middle Initial: Last Name: Last N			
Gender: Male Female Phone #1: Phone #1: Phone #2: Email Address: Coverage Amount: Have you smoked cigarettes in the last 12 months? Yes No Social Security Number: It in bs J.S. Citizen: Marital Status: Select One Marital Status: Select One Middle Initial: Last Name: Middle Initial: Last Name: Middle Initial: Last Name: Middle Initial: Last Name: Last N	City: *	Stato: *	7ID· *
Sender: * Date of Birth: * Phone #2: Email Address: * Coverage Amount * Have you smoked cigarettes in the last 12 months? * Yes ® No Height: * Weight: * Social Security Number: * Person No Social Security Number: * Select One * Social Security Number: * Annual Household Income: * Select One * Select	city.		211.
Phone #1: Phone #2: Email Address: Coverage Amount: Have you smoked cigarettes in the last 12 months? Neight: Weight: Weight: No Social Security Number: Single Married Annual Household Income: Select One Oose Your Beneficiary Deneficiary Deneficiary Sunvives the owner, or none is named, payment will be made to the owner's estate. Wirst Name: Middle Initial: Last Name: Wirst Name: Last Name: Urrance Replacement Dui intend to replace, discontinue, or change any existing life insurance policy? Tes No No No Social Security Number: Select One Date of Birth: Coverage Amount * Coverage Amount * Deneficiary Sunvives the owner, or none is named, payment will be made to the owner's estate. Desposed Insurance Company Name: Coverage Amount * Deneficiary Policy or Contact Number: Coverage Amount * Coverage Amount * Coverage Amount * Deneficiary Date of Birth: Date of Birth: Date of Birth: Coverage Amount * Deneficiary Date of Birth: Date of Birt	Condon t		
Phone #1:	oondon.		
Email Address: Coverage Amount.* Have you snoked cigarettes in the last 12 months? Nes No Height.* Weight.* Social Security Number.* It. In. Ibs Annual Household Income: Select One Sele			
Meight: * Weight: * Social Security Number: * It. in. Ibs	Phone #1: *		Phone #2:
Meight: * Weight: * Social Security Number: * It. in. Ibs			
Annual Household Income: It. In. Ibs It. In. In. Ibs It. Ibs It. In. In. Ibs It. Ibs	Email Address: *	Coverage Amount: *	
It. in. in. ibs Single Married Married			
Marital Status: Solution: No Single Married Annual Household Income: Select One Select One Middle Initial: Last Name: Middle Initial: Last Name: Middle Initial: Last Name: Middle Initial: Last Name: Last Name: Middle Initial: Last Name: Last Name: Life Insurance Replacement Out intend to replace, discontinue, or change any existing life insurance policy? Life Insurance Company Name: Policy or Contact Number: Coverage Amount: Coverage	Height: *	Weight: *	Social Security Number: *
Annual Household Income: * Select One Select	ft. in.	Ibs	
Annual Household Income: * Select One Select	10.0%		
Doose Your Beneficiary beneficiary survives the owner, or none is named, payment will be made to the owner's estate. Irst Name: Middle Initial: Last Name: Last Name: Urrance Replacement Date of Birth: Date of Birth			
Doose Your Beneficiary beneficiary survives the owner, or none is named, payment will be made to the owner's estate. Irst Name: Middle Initial: Last Name: Last Name: Urrance Replacement Date of Birth: Date of Birth	Occupation: *		Annual Household Incomer*
Dose Your Beneficiary beneficiary survives the owner, or none is named, payment will be made to the owner's estate. Irist Name: Middle Initial: Last Name: Wildle Initial: Last Name: Urrance Replacement but intend to replace, discontinue, or change any existing life insurance policy? Life Insurance Company Name: Policy or Contact Number: Coverage Amount: Covera	оссираноп.		
beneficiary survives the owner, or none is named, payment will be made to the owner's estate. Itrist Name: Middle Initial: Last Name: Relationship: Please Specify: Date of Birth: Date			Select Offe
select One ** ** ** ** ** ** ** ** **			
select One ** ** ** ** ** ** ** ** **	beneficiary survives the owner, or none is na		
Surance Replacement ou intend to replace, discontinue, or change any existing life insurance policy?* fes No lease Provide Information about the file insurance company that issued the policy or annuity you wish to replace: Life Insurance Company Name: * Policy or Contact Number: * Coverage Amount: * Coverage Amount: * Diposed Insured e person completing this application the proposed insured?* fes No tomatic Premium Loan Requested madic Premium Loan Requested madic Premium Loan against available cash value in your policy. ct yes below to select this option.*	beneficiary survives the owner, or none is na	Middle Initial:	Last Name:
ou intend to replace, discontinue, or change any existing life insurance policy?* fes No lease Provide Information about the file insurance company that issued the policy or annuity you wish to replace: Life Insurance Company Name: Policy or Contact Number: Coverage Amount: Coverage Amount: Doposed Insured e person completing this application the proposed insured?* fes No tomatic Premium Loan Requested madic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be for you, automatically, by a loan against available cash value in your policy. ct yes below to select this option.*	beneficiary survives the owner, or none is na irst Name: Relationship:	Middle Initial:	Last Name: Date of Birth:
Life Insurance Company Name: * Policy or Contact Number: * Coverage Amount * Diposed Insured e person completing this application the proposed insured? * fes No tomatic Premium Loan Requested matic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be for you, automatically, by a loan against available cash value in your policy. ct yes below to select this option.*	irst Name:	Middle Initial:	Last Name: Date of Birth:
Policy or Contact Number. * Coverage Amount * Doposed Insured a person completing this application the proposed insured? * Tes No tomatic Premium Loan Requested matic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be for you, automatically, by a loan against available cash value in your policy. ct yes below to select this option.*	beneficiary survives the owner, or none is na irst Name: Relationship: Belect One Surrance Replacement ou intend to replace, discontinue, or change res No	Middle Initial: Please Specify:* e any existing life insurance policy? *	Last Name: Date of Birth:
Coverage Amount * Diposed Insured a person completing this application the proposed insured? * Tes No No tomatic Premium Loan Requested matic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be for you, automatically, by a loan against available cash value in your policy. Extress below to select this option.*	beneficiary survives the owner, or none is na irst Name: telationship: select One urance Replacement ou intend to replace, discontinue, or change res No	Middle Initial: Please Specify:* e any existing life insurance policy? *	Last Name: Date of Birth:
posed Insured person completing this application the proposed insured? * tes No tomatic Premium Loan Requested matic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be for you, automatically, by a loan against available cash value in your policy. ct yes below to select this option.*	beneficiary survives the owner, or none is na irst Name: Relationship: Select One Furrance Replacement ou intend to replace, discontinue, or change res No No lease Provide Information about the file insur	Middle Initial: Please Specify:* e any existing life insurance policy? *	Last Name: Date of Birth:
e person completing this application the proposed insured? * tes ◎ No tomatic Premium Loan Requested matic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will be for you, automatically, by a loan against available cash value in your policy. ct yes below to select this option.*	beneficiary survives the owner, or none is na irst Name: Relationship: Select One Purance Replacement ou intend to replace, discontinue, or change res No Life Insurance Company Name: Policy or Contact Number:	Middle Initial: Please Specify:* e any existing life insurance policy? *	Last Name: Date of Birth:
x person completing this application the proposed insured? * es ◎ No tomatic Premium Loan Requested natic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will b for you, automatically, by a loan against available cash value in your policy. tyes below to select this option.*	beneficiary survives the owner, or none is na irst Name: elationship: delect One urance Replacement puintend to replace, discontinue, or change es No ease Provide Information about the file insur Life Insurance Company Name: Policy or Contact Number:	Middle Initial: Please Specify:* e any existing life insurance policy? *	Last Name: Date of Birth:
matic Premium Loan will protect you from having your Whole Life Insurance Policy cancelled because you didn't pay a premium on time. The premium will b for you, automatically, by a loan against available cash value in your policy. ct yes below to select this option.*	beneficiary survives the owner, or none is natirest Name: delationship: delect One urance Replacement but intend to replace, discontinue, or change desse Provide Information about the file insur Life Insurance Company Name: Policy or Contact Number: Coverage Amount	Middle Initial: Please Specify:* e any existing life insurance policy? *	Last Name: Date of Birth:
	beneficiary survives the owner, or none is na irst Name: telationship: Select One Urrance Replacement ou intend to replace, discontinue, or change res No No No No No Policy or Contact Number: Coverage Amount Coverage Amount Coverage Amount Deposed Insured Person completing this application the pre	Middle Initial: Please Specify:* e any existing life insurance policy? * rance company that issued the policy or	Last Name: Date of Birth:
	beneficiary survives the owner, or none is na first Name: Relationship: Select One Purrance Replacement ou intend to replace, discontinue, or change fees No lease Provide Information about the file insur Life Insurance Company Name: Policy or Contact Number: Coverage Amount Diposed Insured a person completing this application the profes No tomatic Premium Loan Rimatic Premium Loan Rimatic Premium Loan will protect you from he matic Premium Loan Rimatic Premiu	Middle Initial: Please Specify:* e any existing life insurance policy? * rance company that issued the policy or oposed insured? * equested wing your Whole Life Insurance Policy co	Date of Birth: Date of Birth: Date of Birth: Date of Birth:

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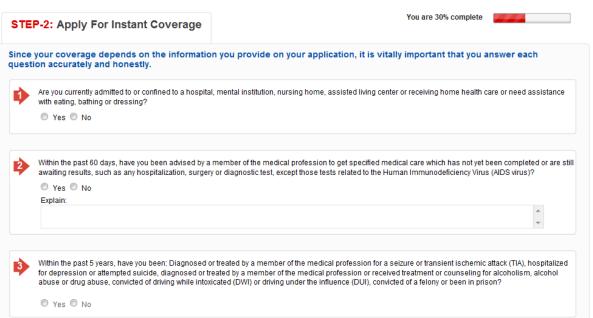


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2 APPLY FOR INSTANT COVERAGE



STEP-2: Apply For Instant Coverage		You are 50% complete	
	nce your coverage depends on the information you provide on your application, it is vitally important that you answer each justion accurately and honestly.		
4		or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue ng disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high bloo italization?	
	○ Yes ○ No		
	(Select all which are applicable):		
	Musculoskeletal disorder, lupus, or other connec	ctive tissue disease.	
	Systemic Lupus Discoid Lupus or lupus that only involves to	the skin	
	Other/unknown		
	Have you ever been hospitalized for this co	ondition?	
	© Yes [©] No		
	Are you considered disabled due to this co	ondition?	
	© Yes © No		
	Do your symptoms involve more than just a	a skin rash?	
	○ Yes ○ No		
	What treatment are you receiving	for this condition? Explain:	

	toid Arthritis
Are you	considered disabled due to this condition?
O Yes	s ◎ No
Have yo	u ever been hospitalized for this condition?
© Yes	s ◎ No
Do you r	require the walking aids or wheelchair?
© Yes	s ◎ No
Do you t	take steroids or Prednisone?
Yes	s ◎ No
☐ Mixed Co	nnective Tissue Disease
Polymyos	sitis or dermatomyositis
Fibromya	Igia
Are you	currently being treated with steroids, Prednisone or narcotic pain medication?
© Yes	S ◎ No
□ Tendoniti	is or tenosynovitis
☐ Tendoniti	is or tenosynovitis
☐ Gout	nritis
Gout Osteoarth	nritis
Gout Osteoarth Osteomye	nritis elitis
Gout Osteoarth Osteomye Is this a	nritis elitis chronic condition?
Gout Osteoarth Osteomye Is this a Yes Have yo	nritis elitis chronic condition? No
Gout Osteoarth Osteomye Is this a Yes Have yo	elitis chronic condition? S O No ut fully recovered?
Gout Osteoarth Osteomye Is this a Yes Have yo Yes Number	nritis elitis chronic condition? s

Do you currently require use of narcotic pain medication?
© Yes [©] No
Osteoporosis
Does this condition cause any restrictions on activity or disability?
◎ Yes ◎ No
Paget's disease of the Bone
Does this involve more than 2 bones?
Yes No
Has this disease resulted in more than 1 fracture?
◎ Yes ◎ No
Are there any restrictions on activity?
◎ Yes ◎ No
Are you considered disabled due to this condition?
© Yes ◎ No
Benign, Non-malignant bone or joint tumor(s)
Have you fully recovered with no evidence of recurrence?
◎ Yes ◎ No
Do you currently have any current tumor that has not been surgically removed?
◎ Yes ◎ No
When was most recent tumor removed?
O to 3 years
Over 3 years
Malignant, cancerous bone or joint tumor(s)
Polymyalgia Rheumatica
Have you had any treatment or symptoms within the past 2 years?
Yes No

	Explain:	
		<u></u>
.ung dise	ease or disorder	
	dicate all of the following for which you have been diagnosed or treated by a member of the medical profes to lung disease or disorder (Select all that apply):	ssion in the past 10 years as
Emp	hysema	
COP	D (Chronic Obstructive Lung Disease) or Chronic Bronchitis	
Have y	ou smoked any tobacco products in the past 2 years?	
© Ye	es O No	
Have y	ou ever required oxygen treatment?	
© Ye	es O No	
Have y	you been hospitalized in the past 5 years for COPD or chronic bronchitis?	
⊚ Ye	es © No	
Are yo	u currently treated with oral steroids or Prednisone?	
⊚ Ye	es © No	
Do you	u currently have any restrictions on activity due to COPD or Chronic Bronchitis?	
© Y€	es © No	
Are yo	u considered disabled due to COPD or Chronic Bronchitis	
◎ Ye	es © No	
Asthma		
Have y	ou been hospitalized in past 2 years for asthma?	
⊚ Ye	es O No	
Are yo	u treated by oral steroids or Prednisone?	
⊚ Ye	es © No	
Do you	u currently have any restrictions on activity due to asthma?	

□ Ві	tronchiectasis
1	Have you ever required oxygen treatment?
	○ Yes ○ No
	Have you been hospitalized for bronchiectasis in the past 5 years?
	© Yes © No
,	Are you considered disabled due to bronchiectasis?
	◎ Yes ◎ No
ı	Do you currently have any restrictions on activity due to bronchiectasis?
	◎ Yes ◎ No
	ronchitis (non chronic)
ı	Do you currently have pneumonia, have had pneumonia within the past 3 months or are recovering from pneumonia?
	◎ Yes ◎ No
1	Have you fully recovered from pneumonia and have no further symptoms?
	◎ Yes ◎ No
1	Have you been advised to have a follow-up Chest X-ray, CT-scan, MRI or other testing related to the lungs that has not been completed or that you
	are awaiting results?
	◎ Yes ◎ No
I	Do you have any other lung or heart problems?
	Explain:
	v v

Spontaneous		
© Trauma		
Other		
Explain:		
	*	
Have you fully recovered from the pneumothorax with no further symptoms?		
○ Yes ○ No		
Pulmonary embolism (blood clot in lung)		
Have you had more than one episode/event associated with a pulmonary embolism?		
○ Yes ○ No		
Have you had a pulmonary embolism within the past 2 years?		
○ Yes ○ No		
Do you require ongoing anticoagulant treatment (Coumadin or Warfarin) to prevent future blood clots?		
○ Yes ○ No		
Was the cause of the embolism due to another disease or disorder?		
○ Yes ○ No		
Explain:		
	*	
Pulmonary Hypertension		
□ Sarcoidosis		
Sleep Apnea		
Were you diagnosed with sleep apnea within the past 6 months?		

Have you	been advised to use c-pap or bi-pap treatment?
Yes	◎ No
D	o you use recommended treatment?
(Yes No
Have you	been advised to have a sleep study that has not yet been completed?
Yes	◎ No
Do you cu	urrently suffer from excessive daytime fatigue?
Yes	◎ No
Lung canc	er
Other	
	Explain:
lotting or bl	leeding disorder, anemia or blood disease
ease indica	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as
lease indica relates to c	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply)
lease indica relates to d	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply)
lease indica relates to d	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year?
lease indica relates to d Anemia Have you	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year?
lease indica relates to d Anemia Have you	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years?
lease indicaterelates to comment of the comment of	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years?
lease indicate relates to continuous formation of the cont	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years?
lease indicate to control to cont	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years? No ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or lia or other bleeding/clotting disorder?
lease indicarelates to concentrate t	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years? No ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or lia or other bleeding/clotting disorder?

	Have you been advised by a member of the medical profession that you have sickle cell trait only?	
	○ Yes ○ No	
	Have you ever been diagnosed with symptomatic sickle cell anemia or required any treatment for sickle cell anemia?	
	○ Yes ○ No	
Was	as the cause of the anemia due to bleeding from the gastrointestinal tract?	
0	Yes No	
	Was the last occurrence of gastrointestinal bleeding within the past 2 years?	
	○ Yes ○ No	
	Was there any cancer or malignancy found to be the cause of the bleeding?	
	Yes No	
	Have the symptoms fully resolved and anemia no longer present?	
	○ Yes ○ No	
	Have you had a colonoscopy with abnormal results in the past 2 years?	
	O Yes O No	
	Have you been advised to have a colonoscopy or other testing involving the gastrointestinal tract that has not yet been	completed?
	O Yes O No	
Other	er	
	Explain:	
	<u></u>	
Diabete	tes treated with insulin or requiring hospitalization	
	e indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in t es to diabetes treated with insulin or requiring hospitalization (select all that apply)	ne past 10 years as
Hav	ve you been prescribed Insulin to treat your diabetes?	

Have you been hospitalized in the past 5 years due to diabetes?	
© Yes ◎ No	
Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?	
© Yes © No	
Have you been diagnosed by a member of the medical profession with heart disease, kidney disease, excessive protein or albumin in the	
urine, or blindness?	
© Yes [©] No	
Have you had any limbs amputated due to diabetes or circulatory problems?	
© Yes © No	
Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?	
© Yes © No	
What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?	
◎ 7.0 orless	
© 7.1-9.99	
© 10.0 or higher	
© unknown	
What was your most recent blood sugar test result?	
© Below 145	
© 145 to 220	
Over 220	
Have you been prescribed oral medications or diet to treat your diabetes?	
© Yes ◎ No	
Have you been hospitalized in the past 5 years due to diabetes?	
◯ Yes ◯ No	
Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?	
© Yes [©] No	

	Have you had any limbs amputated due to diabetes or circulatory problems
	○ Yes ○ No
	Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?
	○ Yes ○ No
	What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?
	○ 7.0 or less
	O 7.1-9.99
	10.0 or higher
	O unknown
	What was your most recent blood sugar test result?
	© Below 145
	© 145 to 220
Lligh bla	Over 220
Please i	od pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as
Please i it relates	od pressure requiring more than 2 medications or hospitalization
Please i it relates	od pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply)
Please i it relates In the	od pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) Pe past 6 months have you had a blood pressure reading over 160/100?
Please i it relates In the	od pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) Pe past 6 months have you had a blood pressure reading over 160/100?
Please in trelates In the	nod pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If a past 6 months have you had a blood pressure reading over 160/100? If a light control of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If a light control of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If a light control of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If a light control of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If a light control of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If a light control of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If a light control of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply)
Please i it relates In the	od pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) Pe past 6 months have you had a blood pressure reading over 160/100? Pe o No Pe you ever been diagnosed with Stroke, Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA), Heart Disease, Congestive Heart re, Peripheral Vascular disease, or disease or disorder of the heart valves?
Please in the latest In the Have Failu	od pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 16
Please i it relates In the	nod pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) If you past 6 months have you had a blood pressure reading over 160/100? If you ever been diagnosed with Stroke, Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA), Heart Disease, Congestive Heart re, Peripheral Vascular disease, or disease or disorder of the heart valves? If you have any cardiac testing or procedures pending or advised to have completed that have not been completed?

	Yes O No				
(Sele	ect all which are applicable):				
■ H	Heart attack or any disease or abnormality of the heart or blood vessels.				
	ease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 ars as it relates to heart attack or disease or abnormality of the heart or blood vessels. (Select all that apply):				
[Heart Attack				
[Stroke or Cerebral Vascular Accident (CVA)				
[Coronary Artery Disease				
[Coronary Bypass surgery, coronary angioplasty, or Stinting of coronary artery or arteries.				
[Congestive Heart Failure				
[Disease of the heart valve or valves				
[Heart Murmur				
	Does your heart murmur cause any restrictions on activity?				
	◎ Yes ◎ No				
	Have you ever had any blackouts or fainting episodes due to your heart murmur?				
	◎ Yes ◎ No				
	Have you ever been diagnosed by a member of the medical profession with a disease or disorder of the heart valves?				
	○ Yes ○ No				
	Have you been diagnosed with Mitral Valve Prolapse (MVP)?				
	O Yes O No				

o within the	a last 6 months	
	e last o montals	
over 6 m	nonths ago	
never ha	ad an echocardiogram	
Have you be	en advised to have an echocardiogram (ultrasound of heart) that has not yet been completed?	
O Yes O	No	
Do you have	any other cardiac testing or procedures pending or advised to have completed that have not yet been con	npleted?
O Yes O	No	
Expla	ain:	
		*
		₩
☐ Irregular he	eartbeat, palpatations, or arrhythmia	
High Blood	Pressure or Hypertension	
Other		
Ex	xplain:	
		A
		*
Ot a land of the l		A \(\nu\)
	al vascular accident (CVA), aneurysm, or any peripheral vascular disease.	A *
Cancer (exclud	ling basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy.	A T
Cancer (exclud	ling basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex.	A *
Cancer (excluding Acquired immu Tested positive	ling basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy.	^ \psi
Cancer (exclud Acquired immu Tested positive	ling basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex. e on an acquired immune deficiency syndrome-related test.	Ŷ
Cancer (exclud Acquired immu Tested positive Nervous system	ling basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex. e on an acquired immune deficiency syndrome-related test.	sion in the past 10
Cancer (exclud Acquired immu Tested positive Nervous systen Please indicate years as it relat	ting basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex. on an acquired immune deficiency syndrome-related test. m disorder or disease. all of the following for which you have been diagnosed or treated by a member of the medical profess	sion in the past 10
Cancer (exclud Acquired immu Tested positive Nervous systen Please indicate years as it relate	ling basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. In e deficiency disease or disorder (AIDS), AIDS-Related Complex. In an acquired immune deficiency syndrome-related test. In disorder or disease. In all of the following for which you have been diagnosed or treated by a member of the medical profess tes to nervous system disease or disorder. (Select all that apply): In cognitive disease or disorder	sion in the past 10
Cancer (exclud Acquired immu Tested positive Nervous systen Please indicate years as it relat	ting basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex. on an acquired immune deficiency syndrome-related test. m disorder or disease. all of the following for which you have been diagnosed or treated by a member of the medical profess tes to nervous system disease or disorder. (Select all that apply): or cognitive disease or disorder	sion in the past 10
Cancer (exclud Acquired immu Tested positive Nervous systen Please indicate years as it relat Dementia c Huntington'	ting basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex. on an acquired immune deficiency syndrome-related test. m disorder or disease. all of the following for which you have been diagnosed or treated by a member of the medical profess tes to nervous system disease or disorder. (Select all that apply): or cognitive disease or disorder	÷
Cancer (exclud Acquired immu Tested positive Nervous systen Please indicate years as it relat Dementia c Huntington'	ting basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex. on an acquired immune deficiency syndrome-related test. m disorder or disease. all of the following for which you have been diagnosed or treated by a member of the medical profess tes to nervous system disease or disorder. (Select all that apply): or cognitive disease or disorder 's Disease lerosis derebral Vascular Accident (CVA)	sion in the past 10
Cancer (exclud Acquired immu Tested positive Nervous systen Please indicate years as it relat Dementia o Huntington Stroke or C Parkinson's	ting basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. une deficiency disease or disorder (AIDS), AIDS-Related Complex. on an acquired immune deficiency syndrome-related test. m disorder or disease. all of the following for which you have been diagnosed or treated by a member of the medical profess tes to nervous system disease or disorder. (Select all that apply): or cognitive disease or disorder 's Disease lerosis derebral Vascular Accident (CVA)	sion in the past 10

	When was your last attack/episode of epilepsy or seizure?
	O -3 years ago
	O 3-7 years ago
	Over 7 years ago
	Are you considered disabled due to seizure disorder or epilepsy?
	○ Yes ○ No
	Is seizure disorder or epilepsy caused by a brain or other nervous system tumor?
	○ Yes ○ No
	Do you have any testing or procedures that have been recommended by a member of the medical profession for seizure disorder or epilepsy
	that has not yet been completed?
	○ Yes ○ No
	Explain:
€ Ha Pa	is the tremor been present for less than 2 years? Yes No is the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no rkinson's disease or other underlying cause? Yes No
€ Ha Pa	Yes No Is the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no rkinson's disease or other underlying cause?
€ Ha Pa	Yes No six the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no rkinson's disease or other underlying cause? Yes No Do you have any testing or procedures with respect to the tremor that have been recommended by a member of the medical profession that has not yet been completed?

	🔲 Quadriplegia or tetraplegia
	Paraplegia or Paraparesis
	Hemiplegia or Paraparesis Hemiplegia or hemaparesis
	Non-paralyzing injury to spinal cord
	□ Spondylosis
	Herniated disc or compression of the spinal cord
	Other Spinal Cord disease, disorder or injury
	Explain:
	Do you currently use a wheel chair?
	O Yes No
	Do you currently require the use of narcotics to control pain?
	O Yes O No
	Do you currently require walking aids?
	O Yes O No
	Are you considered disabled due to the spinal cord injury or disease?
	◯ Yes ◯ No
	Tumor of the nervous system or brain
	Tumor of the nervous system or brain
	Tumor of the nervous system or brain Was the tumor considered cancerous or malignant?
	□ Tumor of the nervous system or brain Was the tumor considered cancerous or malignant? ○ Yes ○ No
	Tumor of the nervous system or brain Was the tumor considered cancerous or malignant? Yes No Was the tumor a brain tumor?
	□ Tumor of the nervous system or brain Was the tumor considered cancerous or malignant? ○ Yes ○ No Was the tumor a brain tumor? ○ Yes ○ No
	Tumor of the nervous system or brain Was the tumor considered cancerous or malignant? Yes No Was the tumor a brain tumor? Yes No Has the brain tumor been surgically removed?
	□ Tumor of the nervous system or brain Was the tumor considered cancerous or malignant? ○ Yes ○ No Was the tumor a brain tumor? ○ Yes ○ No Has the brain tumor been surgically removed? ○ Yes ○ No
-	Tumor of the nervous system or brain Was the tumor considered cancerous or malignant? Yes No Was the tumor a brain tumor? Yes No Has the brain tumor been surgically removed? Yes No Was the brain tumor removed within the past 10 years?
	Tumor of the nervous system or brain Was the tumor considered cancerous or malignant? Yes No Was the tumor a brain tumor? Yes No Has the brain tumor been surgically removed? Yes No Was the brain tumor removed within the past 10 years? Yes No

Was the tumor a spinal cord tumor? Yes No Was the tumor surgically removed Yes No Was the tumor removed within the past 2 years? Yes No Do you have any neurological testing or procedure that has been recommended by a medical professional that h completed? Yes No Explain: Depression, Anxiety, or other psychological condition Rease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the relates to depression, anxiety, or other psychological condition: (Select all that apply): Bipolar Schizophrenia Depression Have you been hospitalized for this condition in the past 5 years? Yes No Have you ever attempted suicide? Yes No Are you considered disabled due to this condition?	
Was the tumor surgically removed Yes No Was the tumor removed within the past 2 years? Yes No Do you have any neurological testing or procedure that has been recommended by a medical professional that h completed? Yes No Explain: Depression, Anxiety, or other psychological condition Rease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the relates to depression, anxiety, or other psychological condition: (Select all that apply): Bipolar Schizophrenia Depression Have you been hospitalized for this condition in the past 5 years? Yes No Have you ever attempted suicide? Yes No	
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© Yes © No Do you have any neurological testing or procedure that has been recommended by a medical professional that h completed? © Yes © No Explain: Depression, Anxiety, or other psychological condition lease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the relates to depression, anxiety, or other psychological condition: (Select all that apply): □ Bipolar □ Schizophrenia □ Depression Have you been hospitalized for this condition in the past 5 years? ○ Yes ○ No Have you ever attempted suicide? ○ Yes ○ No	
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Explain: Depression, Anxiety, or other psychological condition lease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the relates to depression, anxiety, or other psychological condition: (Select all that apply): Bipolar Schizophrenia Depression Have you been hospitalized for this condition in the past 5 years? Yes No Have you ever attempted suicide? Yes No	
Depression, Anxiety, or other psychological condition lease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the relates to depression, anxiety, or other psychological condition: (Select all that apply): Bipolar Schizophrenia Depression Have you been hospitalized for this condition in the past 5 years? Yes No Have you ever attempted suicide? Yes No	
lease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the relates to depression, anxiety, or other psychological condition: (Select all that apply): Bipolar	
lease indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the relates to depression, anxiety, or other psychological condition: (Select all that apply): Bipolar	
☐ Depression Have you been hospitalized for this condition in the past 5 years? ○ Yes ○ No Have you ever attempted suicide? ○ Yes ○ No	
Have you been hospitalized for this condition in the past 5 years? Yes No Have you ever attempted suicide? Yes No	
○ Yes ○ NoHave you ever attempted suicide?○ Yes ○ No	
Have you ever attempted suicide? O Yes O No	
© Yes [®] No	
Are you considered disabled due to this condition?	
© Yes [©] No	
Anxeity	
Have you been hospitalized for this condition in the past 5 years?	
○ Yes ○ No	
Have you ever attempted suicide?	

Other		
	Explain:	
		₹
Bells Palsy		
Have you be	en diagnosed by a member of the medical profession with Bells Palsy within the past 6 months?	
○ Yes ○	No	
Trigeminal Ne	uralgia	
Have you ha	d surgery for trigeminal neuralgia?	
○ Yes ○		
Have	you fully recovered from the surgery?	
© Y	es O No	
Has surgery	been recommended that has not been completed?	
O Yes O	No	
Thoracic Outle	at Syndrome	
Narcolepsy		
Were you firs	st diagnosed by a member of the medical profession with Narcolepsy within the past 2 years?	
O Yes O	No	
Have you ha	d any symptoms of narcolepsy in the past year?	
O Yes O	No	
Other nervous	system disorder or disease	
Expl	ain:	

☐ Kidney Disease	
Blockage of the renal (kidney) arteries	
Hypertensive renal (kidney) disease	
Cancer of the kidney	
Had dialysis or been advised to have dialysis?	
Kidney failure	
Glomerulonephritis, nephritic or nephrotic syndrome	
Polycystic kidney disease	
Kidney stones	
☐ Kidney infection	
Did your kidney infection occur in the past 3 months?	
© Yes © No	
Have you fully recovered from your kidney infection	
○ Yes ○ No	
Cother Cother	
Explain:	
	^
	¥
☐ Hepatitis B or C	
□ Hepatitis A	
Have you fully recovered from Hepatitis A?	
O Yes O No	
Non-viral hepatitis	
□ Enlarged liver	
Cirrhosis of the liver	
Primary Biliary Cirrhosis	

Have you been advised by member of the medical profession that your liver enzymes or liver function tests are abnormal or elevated?
O Yes No
Have you been advised by a member of the medial profession that the cause of fatty liver is related to alcohol use?
O Yes No
Have you had a liver biopsy or has a liver biopsy been recommended by a member of the medical profession?
O Yes O No
Have you been diagnosed by a member of the medical profession with Non-Alcoholic Steatohepatitis (NASH)?
O Yes No
Pancreatitis
Tumor or Cancer of the Pancreas
Crohn's or ulcerative colitis
Do you use steroids or immunosuppressive drugs for treatment?
O Yes No
Have you been hospitalized for Crohn's or ulcerative colitis in the past 5 years?
O Yes O No
Did you require surgery or have you been advised by a member of the medical profession to have surgery for Crohn's or ulcerative colitis which
has not been performed?
O Yes No
Have you had an attack of Crohn's or ulcerative colitis within the past year?
O Yes O No
Does Crohn's or ulcerative colitis limit normal activity or are you considered disabled due to this condition?
O Yes No
Has a member of the medical profession advised you to have a colonoscopy or other test related to the gastrointestinal tract that has not been
completed?
Yes No

Alzheimer's, schizophrenia, bipolar or mental disorder.	
Please indicate all of the following for which you have been diagnose it relates to alzheimer's, schizophrenia, bipolar or mental disorder (so	d or treated by a member of the medical profession in the past 10 years as elect all that apply) :
Alzheimer's	
Schizophrenia	
Bipolar	
Attempted Suicide	
Depression	
Have you been hospitalized for this condition in the past 5 years?	
© Yes [©] No	
Have you ever attempted suicide?	
○ Yes ○ No	
Are you considered disabled due to this condition?	
Yes No	
☐ Anxiety	
Have you been hospitalized for this condition in the past 5 years?	
Yes No	
Have you ever attempted suicide?	
O Yes O No	
Are you considered disabled due to this condition?	
O Yes O No	
Other	
Explain:	
	A
	▼

CONTINUE

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If med question decline:







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GET A QUOTE & CHOOSE COVERAGE





PAYMENT OPTIONS

We're sorry, based on the information provided, the application process can not be completed online. If you would like to submit an application for consideration, please click the "Print Application" below, complete the application, make sure it's signed by the person to be covered, and mail it to:

American National Life Insurance Company P.O. Box 696700 San Antonio, TX 78269

Note: You MUST have Adobe Acrobat Reader 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain

Click here to "Print your application".

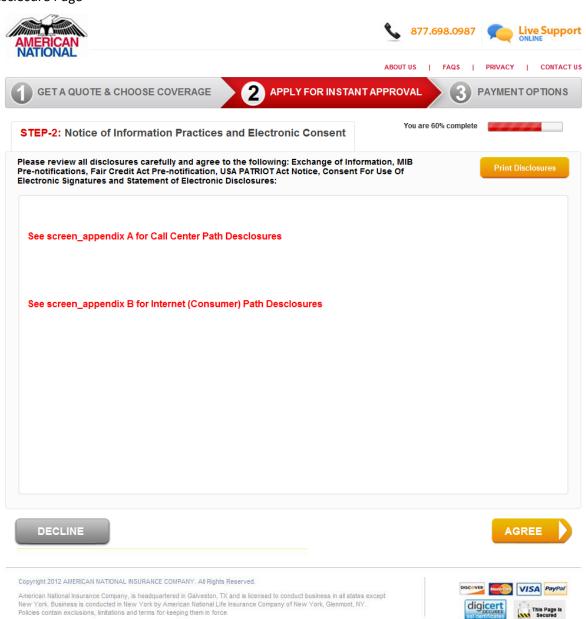
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10498-I

Disclosure Page



10498-I

If decline -







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GET A QUOTE & CHOOSE COVERAGE



2 APPLY FOR INSTANT COVERAGE



PAYMENT OPTIONS

Application process options

Without the required acceptance of the Notice of Information Practices and Electronic Consent, we cannot continue online processing of your application.

- $\ igodots$ Option 1: Continue with electronic process.
- Option 2: I would prefer to print my application, sign it, and send it to American National Insurance Company. I understand that, if approved, I will receive my policy in the mail and that I must remit my initial premium before any insurance will go into effect.
- Option 3: Please discontinue processing my application. I understand that I may return at a future date and apply again but I will have to complete a new application at that time.



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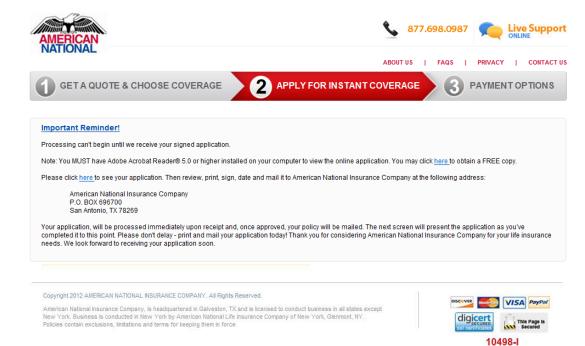
American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, Glenmont, NY. Policies contain exclusions, limitations and terms for keeping them in force.



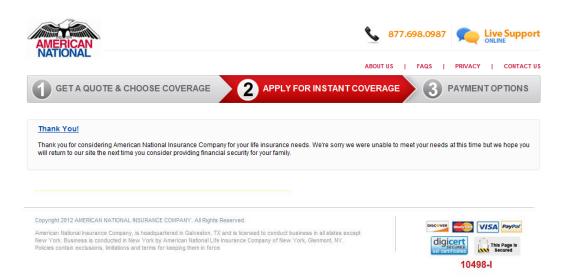
10498-I

Ex opt 1 – go to Disclosure Page

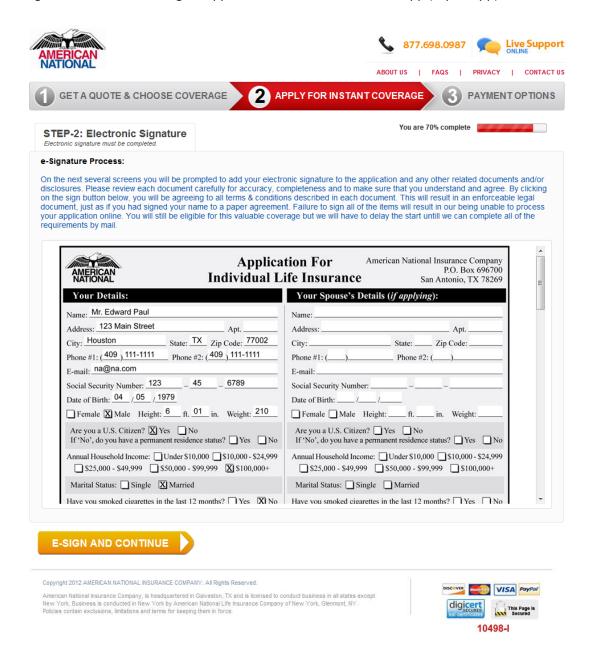
Ex opt 2 -



Ex opt 3 -



If agree from Disclosure Page – App is scrollable to review entire app (top of app)



Bottom of app... cont...



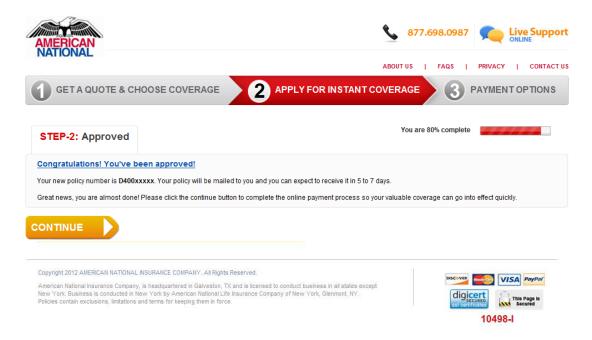


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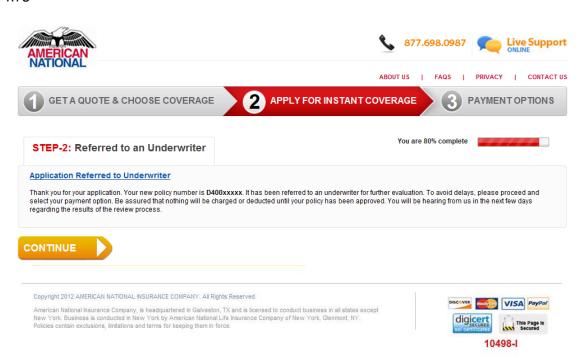
American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York, Business is conducted in New York by American National Life Insurance Company of New York, Glenmont, NY. Policies contain exclusions, limitations and terms for keeping them in force.

DISCOVER VISA PayPar 10498-I

Approve -



RTU



Your Details: Your Spouse's Details (if applying): Name: Mr. Edward Paul Name: Address: Apt. Apt. Address: Apt. Apt. City: State: Zip Code: Phone #1: () Phone #2: () E-mail: E-mail: E-mail: E-mail:	_
Address: 123 Main Street Apt. Address: Apt. City: Houston State: TX Zip Code: 77002 City: State: Zip Code: Phone #1: (409) 111-1111 Phone #2: (409) 111-1111 Phone #1: () Phone #2: ()	_
City: Houston State: TX Zip Code: 77002 City: State: Zip Code: Phone #1: (409) 111-1111 Phone #2: (409) 111-1111 Phone #1: () Phone #2: ()	_
City: Houston State: TX Zip Code: 77002 City: State: Zip Code: Phone #1: (409) 111-1111 Phone #2: (409) 111-1111 Phone #1: () Phone #2: ()	
Phone #1: (409) 111-1111 Phone #2: (409) 111-1111 Phone #2: () Phone #2: ()	
Social Security Number: 123 45 6789	
Date of Birth:/	
Female Male Height: 6 ft. 01 in. Weight: 210 Female Male Height: ft. in. Weight:	
Are you a U.S. Citizen? X Yes No If 'No', do you have a permanent residence status? Yes No If 'No', do you have a permanent residence status? Yes	□No
Annual Household Income: Under \$10,000 \ \$10,000 - \$24,999 \ \$25,000 - \$49,999 \ \$50,000 - \$99,999 \ \X \$100,000+ \ \$25,000 - \$49,999 \ \$50,000 - \$99,999 \ \$100	All the second s
Marital Status: Single Married Marital Status: Single Married	
Have you smoked cigarettes in the last 12 months? The Yes X No Have you smoked cigarettes in the last 12 months? Yes	☐ No
Occupation: franchise owner Occupation:	
Your Amount of Coverage & Beneficiary: Your Spouse's Coverage & Beneficiary:	
Plan: BudgetGuard 7 Year Term Plan:	
Amount (choose one): Sxxx,xxx Sxxx,xxx Sxxx,xxx	
Sxxx,xxx	<u> </u>
Beneficiary: Ruth Paul Beneficiary:	
Date of Birth: 03 / 10 / 1980 Relationship: Spouse Automatic Premium Loan Provision Requested? Yes X No Date of Birth: /// Relationship:	No
IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? Yes X No IMPORTANT: Do you intend to replace, discontinue, or any existing life insurance policy? Yes No	change
If 'Yes', name of company and policy number(s) if available: If 'Yes', name of company and policy number(s) if available:	e:
Your Health: Your Spouse's Health (if applying):	
1. Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: heart attack, disease or abn of the heart or blood vessels, stroke, cerebral vascular accident (CVA), aneurysm, peripheral vascular disease, cancer (excluding be squamous cell skin cancer), leukemia, lymphoma, malignancy, nervous system disease or disorder, hepatitis C, kidney, liver, pancrea or disorder, Alzheimer's, schizophrenia, bipolar, mental disorder, or as having an acquired immune deficiency disease or disorder AIDS-Related Complex, or tested positive on an acquired immune deficiency syndrome-related test?	s disease
You Yes X No Your Spouse Yes No 10498-AR Continued on back	

	Your Health:	Your Spouse's Health (if applying):
	attack (TIA), hospitalized for depression or attempted suicide, diag	member of the medical profession for a seizure or transient ischemic gnosed or treated by a member of the medical profession or received se, convicted of driving while intoxicated (DWI) or driving under the Your Spouse Yes No
3.	are you currently admitted to or confined to a hospital, mental institute care or need assistance with eating, bathing or dressing?	titution, nursing home, assisted living center or receiving home health
	You Yes X No	Your Spouse Yes No
4.	connective tissue disease, lung disease or disorder, clotting or bleed requiring hospitalization, high blood pressure requiring more than 2 n treatment, test results, diagnoses, medications, etc.)	member of the medical profession for: musculoskeletal disorder, lupus, ling disorder, anemia or blood disease, diabetes treated with insulin or medications or hospitalization? If "Yes", provide details below (dates of
	You Yes X No Details:	Your Spouse Yes No Details:
		·
5.		ne medical profession to get specified medical care which has not yet tion, surgery or diagnostic test, except those tests related to the Human elow: Your Spouse Yes No Details:
	If you have more details, please inclu	de them on a separate sheet of paper
	Your Payment — choose one:	ие тет он и зеригие знеег ој рирег
_		
		; follows
I/v	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a	
I/v 1.	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d	deposit slip when providing savings account.)
I/v 1.	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d Charge monthly premiums to my: Visa MasterCard	deposit slip when providing savings account.) Discover // // // // // // // // // // // // //
I/v 1. 2. 3.	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d Charge monthly premiums to my: Visa MasterCard Bill me/us. (Send no money now.)	count. deposit slip when providing savings account.) Discover (Account Number) (Exp. Date)
I/v 1. 2. 3.	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d Charge monthly premiums to my: Visa MasterCard Bill me/us. (Send no money now.) Agreements and Your Authorization to Obtain, Release	Discover (Account Number) (Exp. Date)
I/v 1. 2. 3. I to the issisted this will but Cool I a ph face (Michael and II).	Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a did the Charge monthly premiums to my: Wisa MasterCard Bill me/us. (Send no money now.) Agreements and Your Authorization to Obtain, Released and agree: that the answers in this application are, the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be sued and the amount of premium that will be charged and will acome a part of the Policy; that any material misstatement or missions may cause the policy to be void; that the Company will have no liability until a policy is issued and the first premium due paid in full while I am alive and in the same health condition as secribed above; that if my spouse and I request life insurance on its application that my personal financial and health information ritten on it will be made part of the policy issued to not only me at also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application.	Discover (Exp. Date) ase and Disclose Medical Information: or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address. • I acknowledge receiving the Exchange of Information Notice. • Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
I/v 1. 2. 3. I to the iss be on had is deethir wire but Co. I a ph face (N he and You	Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a did the Charge monthly premiums to my: Visa MasterCard Bill me/us. (Send no money now.) Agreements and Your Authorization to Obtain, Release and example of the policy is an application are, the best of my knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be sued and the amount of premium that will be charged and will be come a part of the Policy; that any material misstatement or missions may cause the policy to be void; that the Company will are no liability until a policy is issued and the first premium due paid in full while I am alive and in the same health condition as a secribed above; that if my spouse and I request life insurance on is application that my personal financial and health information ritten on it will be made part of the policy issued to not only me at also my spouse; and that if I do not agree, I may contact the company and receive a separate application. Buthorize any physician, medical practitioner, hospital, clinic, narmacy, pharmacy benefit manager or other medical-related acility, insurance company, the Medical Information Bureau and the or medical care, advice or treatment provided to me to give by such information to American National Insurance Company,	Discover (Account Number) (Exp. Date) ase and Disclose Medical Information: or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address. • I acknowledge receiving the Exchange of Information Notice. • Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement

<u>Screen appendix B – Internet (Customer) Path</u>

You have now provided the personal information needed to evaluate your insurance application. Before we can complete your application review, we must ask you to read and accept certain disclosures about our information practices and provide us with any necessary authorizations. These disclosures begin below.

Exchange of Information Notice

We are required to provide you the following disclosures to you:

Medical Information Bureau, Inc. (MIB) Pre-Notification

Information regarding your insurability will be treated as confidential. American National Insurance Company, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American National Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential.

You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA PATRIOT Act Notice

The USA PATRIOT Act requires that we establish an Anti-Money Laundering (AML) Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

Consent For Use Of Electronic Signatures and Records - Before we can process your application online, we will need you to sign it together with certain other documents. This process will bind your electronic "signature" to these documents such that no changes can ever be made to the information you provided without invalidating your signature. This provides you with the assurance that any information you provide will be retained exactly as you provided it - guaranteed! Also, please be assured that all of your information is subject to our strictest security and privacy standards. Click on the Security & Privacy link below for more information. Please read and acknowledge your consent to use electronic signatures and agreement to receive required notices and documents electronically.

Consent for use of electronic signatures and records:

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application ("Required Information"). With your consent, American National Insurance Company can deliver Required Information to you by: Displaying or delivering the Required Information electronically, and Requesting that you print or download the Required Information and retain it for your records.

This notice contains important information that you are entitled to receive before you consent to electronic delivery of required information. Your consent also permits the general use of electronic records and electronic signatures in connection with your application. Please read this notice carefully and print or download a copy for your files.

After you have read this information, if you agree to receive Required Information from American National Insurance Company electronically, and if you agree to the general use of electronic records and electronic signatures in connection with your relationship with American National Insurance Company, please click on the "Accept" button at the bottom.

Statement of electronic disclosures:

You may request to receive Required Information on paper, but if you do not consent to electronic delivery of Required Information, American National Insurance Company cannot proceed with the acceptance and processing of your electronic application.

If you consent to electronic delivery of Required Information, you may withdraw that consent at any time. However, if you withdraw your consent we will not be able to continue processing your application.

If you consent to electronic disclosures, that consent applies to all Required Information American National Insurance Company gives you or receives from you in connection with your life insurance application and the associated notices, disclosures, and other documents.

The Required Information that may covered by the consent includes, among other things:

Medical Information Bureau (MIB) Pre-Notification Authorization to release personal health information Notice of Insurance Information Practices

Notices regarding policy replacement and adverse underwriting decisions

You agree to print out or download Required Information when we advise you to do so and keep it for your records. If you have any trouble printing out or downloading any Required Information, you may call American National Insurance Company at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time and request paper copies. If you need to update your e-mail address or other contact information with American National Insurance Company, you may do so by calling us at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the required information via email. Upon receipt, we will update your records.

If you wish to withdraw your consent to electronic disclosures, you may do so by calling us at 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time or by clicking on the Contact Us link at the bottom and sending the request via email. After consenting to receive and deliver Required Information electronically, you may, upon request, obtain a paper copy of the Required Information by calling 1-877-697-0098 Monday through Friday from 9 a.m. to 7 p.m. Eastern Time.

Software and Hardware Requirements:

To access and retain Required Information from American National Insurance Company, you must:

- 1. Be able to view the disclosures on your monitor and send screen prints to your printer, which can be done with your browser.
- 2. Have access to an Internet service account and use Internet Explorer V4.0 and above or Netscape Navigator V4.x and above to receive required information
- 3. Be able to send and receive e-mail that contains hyperlinks to Websites in order for American National Insurance Company to deliver required information to you

If you do not have the required software and/or hardware, or if you do not wish to use electronic records and signatures for any other reason, you can request paper copies of the application document(s) to be sent to you by clicking on the Contact Us link at the bottom and sending us your request.

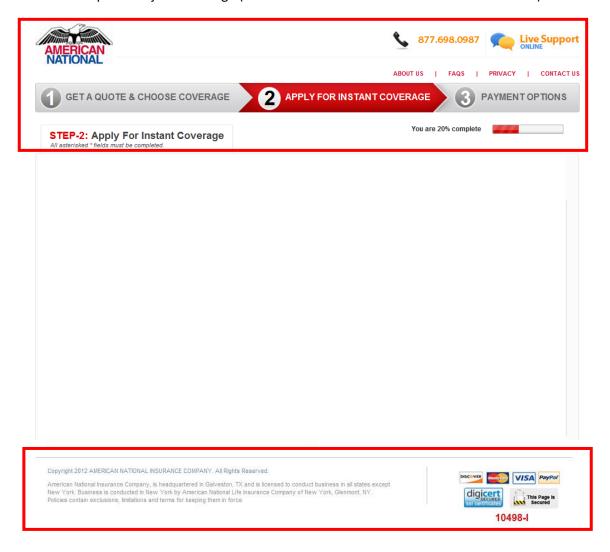
Your consent does not mean that American National Insurance Company must provide the Required Information electronically. American National Insurance Company may, at their option, deliver Required Information on paper if it chooses to do so. American National Insurance Company may also require that certain communications from you be delivered to American National Insurance Company on paper at a specified address.

I have read the information about the use of electronic records, disclosures, notices, and e-mail, and consent to the use of electronic records for the delivery of required information in connection with my life insurance application with American National Insurance Company. I have been able to view this information using my computer and software. I have an account with an internet service provider, and I am able to send e-mail and receive e-mail with hyperlinks to websites and attached files. I also consent to the use of electronic records and electronic signatures in connection with my life insurance application with American National Insurance Company in place of written documents and

handwritten signatures. I am consenting on behalf of all joint applicants identified in the application. I am authorized to consent on their behalf.

Appendix C -

Website template subject to change (indicated in red boxes below – header and footer):







ABOUT US | FAQS | PRIVACY | CONTACT US





estion accurately and	honestly.	nformation you pro	ovide on your	application, it is vitally important that you answer each	
upply Your Infor	mation				
First Name: *		Middle Initial:		Last Name: *	
Primary Mailing Address: *					
Frimary maining Address.					
City: *		State: *		ZIP: *	
			•		
Gender: *		Date of Birth: *			
Male Female		•	•		
Phone #1: *				Phone #2:	
Email Address: *		Coverage Amour	nt: *	Have you smoked cigarettes in the last 12	
Zilian Maaroool				months?*	
Height: *		Weight: *		○ Yes ○ No Social Security Number: *	
ft.	in.	vveignt: "	lbs	Social Security number:	
14			100		
U.S. Citizen: *		Marital Status: * Single Mai	rriad		
		○ Silligle ○ Illa	illed		
Occupation: *	ation: *			Annual Household Income: *	
noose Your Ben				Select One	
noose Your Ben- beneficiary survives the ow		ned, payment will be m	nade to the owner's		
beneficiary survives the ow		Middle Initial:	ade to the owner's	s estate. Last Name:	
beneficiary survives the ow			ade to the owners	s estate.	
beneficiary survives the ow First Name: Relationship:	ner, or none is nan	Middle Initial: Please Specify:*		s estate. Last Name: Date of Birth:	
beneficiary survives the ow First Name: Relationship: Select One Surance Replace ou intend to replace, disco	ement ntinue, or change	Middle Initial: Please Specify:* any existing life insura	ance policy? *	Last Name: Date of Birth:	
beneficiary survives the ow First Name: Relationship: Select One Surance Replace ou intend to replace, disco Yes No	ement ntinue, or change	Middle Initial: Please Specify:* any existing life insura	ance policy? *	Last Name: Date of Birth:	
First Name: Relationship: Select One Surance Replace ou intend to replace, disco Yes No	ement ntinue, or change	Middle Initial: Please Specify:* any existing life insura	ance policy? *	Last Name: Date of Birth:	
beneficiary survives the ow First Name: Relationship: Select One Surance Replace ou intend to replace, disco	ner, or none is nan	Middle Initial: Please Specify:*		s estate. Last Name: Date of Birth:	
First Name: Relationship: Select One Surance Replace ou intend to replace, disco Yes No Please Provide Information a	ement ntinue, or change	Middle Initial: Please Specify:* any existing life insura	ance policy? *	Last Name: Date of Birth:	
First Name: Relationship: Select One Surance Replace ou intend to replace, disco Yes No	ement ntinue, or change	Middle Initial: Please Specify:* any existing life insura	ance policy? *	Last Name: Date of Birth:	
First Name: Relationship: Select One Surance Replace ou intend to replace, disco Yes No Nelease Provide Information a Life Insurance Comp Policy or Conta	ement ntinue, or change	Middle Initial: Please Specify:* any existing life insura	ance policy? *	Last Name: Date of Birth:	
First Name: Relationship: Select One Surance Replace ou intend to replace, disco Yes No Nelease Provide Information a Life Insurance Comp Policy or Conta	ement Intinue, or change about the file insura bany Name: act Number: ge Amount:	Middle Initial: Please Specify:* any existing life insurance company that issued the company of the company that issued the company of the	ance policy? *	Last Name: Date of Birth:	
First Name: Relationship: Select One Surance Replace ou intend to replace, disco Yes No No No No No No No No No N	ement Intinue, or change. about the file insura bany Name: act Number: ge Amount: Implication the property of the property o	Middle Initial: Please Specify:* any existing life insurance company that issue the company that is the company	ance policy? * Jed the policy or ar	Last Name: Date of Birth:	

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American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York, Business is conducted in New York by American National Life Insurance Company of New York, Glenmont, NY. Policies contain exclusions, limitations and terms for keeping them in force:









ABOUT US | FAQS | PRIVACY | CONTACT US







You are 30% complete STEP-2: Apply For Instant Coverage Since your coverage depends on the information you provide on your application, it is vitally important that you answer each question accurately and honestly. Are you currently admitted to or confined to a hospital, mental institution, nursing home, assisted living center or receiving home health care or need assistance with eating, bathing or dressing? O Yes O No Within the past 60 days, have you been advised by a member of the medical profession to get specified medical care which has not yet been completed or are still awaiting results, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? O Yes O No Explain: Within the past 5 years, have you been: Diagnosed or treated by a member of the medical profession for a seizure or transient ischemic attack (TIA), hospitalized for depression or attempted suicide, diagnosed or treated by a member of the medical profession or received treatment or counseling for alcoholism, alcohol abuse or drug abuse, convicted of driving while intoxicated (DWI) or driving under the influence (DUI), convicted of a felony or been in prison? O Yes No

CONTINUE

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American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life insurance Company of New York, Glenmont, NY. Policies contain exclusions, limitations and terms for keeping them in force.

DISCOVER VISA PayPar

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ABOUT US | FAQS | PRIVACY | CONTACT US



2 APPLY FOR INSTANT COVERAGE



STE	P-2: Apply For Instant Coverage	You are 50% complete	
	nce your coverage depends on the information you provide on your application, it is vitally important that you answer each uestion accurately and honestly.		
4		or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue ng disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high bloo italization?	
	○ Yes ○ No		
	(Select all which are applicable):		
	Musculoskeletal disorder, lupus, or other connec	ctive tissue disease.	
	Systemic Lupus Discoid Lupus or lupus that only involves to	the skin	
	Other/unknown		
	Have you ever been hospitalized for this co	ondition?	
	© Yes ◎ No		
	Are you considered disabled due to this co	ondition?	
	© Yes © No		
	Do your symptoms involve more than just a	a skin rash?	
	○ Yes ○ No		
	What treatment are you receiving	for this condition? Explain:	

	toid Arthritis
Are you	considered disabled due to this condition?
O Yes	s ◎ No
Have yo	u ever been hospitalized for this condition?
© Yes	s ◎ No
Do you r	require the walking aids or wheelchair?
© Yes	s ◎ No
Do you t	take steroids or Prednisone?
Yes	s ◎ No
☐ Mixed Co	nnective Tissue Disease
Polymyos	sitis or dermatomyositis
Fibromya	Igia
Are you	currently being treated with steroids, Prednisone or narcotic pain medication?
© Yes	s ◎ No
□ Tendoniti	is or tenosynovitis
☐ Tendoniti	is or tenosynovitis
☐ Gout	nritis
Gout Osteoarth	nritis
Gout Osteoarth Osteomye	nritis elitis
Gout Osteoarth Osteomye Is this a	nritis elitis chronic condition?
Gout Osteoarth Osteomye Is this a Yes Have yo	nritis elitis chronic condition? No
Gout Osteoarth Osteomye Is this a Yes Have yo	elitis chronic condition? S O No ut fully recovered?
Gout Osteoarth Osteomye Is this a Yes Have yo Yes Number	nritis elitis chronic condition? s

Do you currently require use of narcotic pain medication?
© Yes [©] No
Osteoporosis
Does this condition cause any restrictions on activity or disability?
◎ Yes ◎ No
Paget's disease of the Bone
Does this involve more than 2 bones?
Yes No
Has this disease resulted in more than 1 fracture?
◎ Yes ◎ No
Are there any restrictions on activity?
◎ Yes ◎ No
Are you considered disabled due to this condition?
© Yes ◎ No
Benign, Non-malignant bone or joint tumor(s)
Have you fully recovered with no evidence of recurrence?
◎ Yes ◎ No
Do you currently have any current tumor that has not been surgically removed?
◎ Yes ◎ No
When was most recent tumor removed?
O to 3 years
Over 3 years
Malignant, cancerous bone or joint tumor(s)
Polymyalgia Rheumatica
Have you had any treatment or symptoms within the past 2 years?
◎ Yes ◎ No

	Explain:	
		<u></u>
.ung dise	ease or disorder	
	dicate all of the following for which you have been diagnosed or treated by a member of the medical profes to lung disease or disorder (Select all that apply):	ssion in the past 10 years as
Emp	hysema	
COP	D (Chronic Obstructive Lung Disease) or Chronic Bronchitis	
Have y	ou smoked any tobacco products in the past 2 years?	
© Ye	es O No	
Have y	ou ever required oxygen treatment?	
© Ye	es O No	
Have y	you been hospitalized in the past 5 years for COPD or chronic bronchitis?	
⊚ Ye	es © No	
Are yo	u currently treated with oral steroids or Prednisone?	
⊚ Ye	es © No	
Do you	u currently have any restrictions on activity due to COPD or Chronic Bronchitis?	
© Y€	es © No	
Are yo	u considered disabled due to COPD or Chronic Bronchitis	
◎ Ye	es © No	
Asthma		
Have y	ou been hospitalized in past 2 years for asthma?	
⊚ Ye	es O No	
Are yo	u treated by oral steroids or Prednisone?	
⊚ Ye	es © No	
Do you	u currently have any restrictions on activity due to asthma?	

□ Ві	tronchiectasis
1	Have you ever required oxygen treatment?
	○ Yes ○ No
	Have you been hospitalized for bronchiectasis in the past 5 years?
	© Yes © No
,	Are you considered disabled due to bronchiectasis?
	◎ Yes ◎ No
ı	Do you currently have any restrictions on activity due to bronchiectasis?
	◎ Yes ◎ No
	ronchitis (non chronic)
ı	Do you currently have pneumonia, have had pneumonia within the past 3 months or are recovering from pneumonia?
	◎ Yes ◎ No
1	Have you fully recovered from pneumonia and have no further symptoms?
	◎ Yes ◎ No
1	Have you been advised to have a follow-up Chest X-ray, CT-scan, MRI or other testing related to the lungs that has not been completed or that you
	are awaiting results?
	◎ Yes ◎ No
I	Do you have any other lung or heart problems?
	Explain:
	v v

Spontaneous		
© Trauma		
Other		
Explain:		
	*	
Have you fully recovered from the pneumothorax with no further symptoms?		
○ Yes ○ No		
Pulmonary embolism (blood clot in lung)		
Have you had more than one episode/event associated with a pulmonary embolism?		
○ Yes ○ No		
Have you had a pulmonary embolism within the past 2 years?		
○ Yes ○ No		
Do you require ongoing anticoagulant treatment (Coumadin or Warfarin) to prevent future blood clots?		
○ Yes ○ No		
Was the cause of the embolism due to another disease or disorder?		
○ Yes ○ No		
Explain:		
	*	
Pulmonary Hypertension		
□ Sarcoidosis		
Sleep Apnea		
Were you diagnosed with sleep apnea within the past 6 months?		

Have you	been advised to use c-pap or bi-pap treatment?
Yes	◎ No
D	o you use recommended treatment?
(Yes No
Have you	been advised to have a sleep study that has not yet been completed?
Yes	◎ No
Do you cu	urrently suffer from excessive daytime fatigue?
Yes	◎ No
Lung canc	er
Other	
	Explain:
lotting or bl	leeding disorder, anemia or blood disease
ease indica	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as
lease indica relates to c	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply)
lease indica relates to d	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply)
lease indica relates to d	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year?
lease indica relates to d Anemia Have you	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year?
lease indica relates to d Anemia Have you	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years?
lease indicaterelates to comment of the comment of	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years?
lease indicate relates to continuous formation of the cont	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years?
lease indicate to control to cont	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years? No ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or lia or other bleeding/clotting disorder?
lease indicarelates to concentrate t	ate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as clotting or bleeding disorder, anemia or blood disease (select all that apply) been hospitalized for anemia in the past year? No anemia caused you to receive a blood transfusion in the past 5 years? No ever been diagnosed with cancer (excluding basal cell or squamous cell skin cancer), leukemia, lymphoma, multiple myeloma, or lia or other bleeding/clotting disorder?

	Have you been advised by a member of the medical profession that you have sickle cell trait only?	
	○ Yes ○ No	
	Have you ever been diagnosed with symptomatic sickle cell anemia or required any treatment for sickle cell anemia?	
	○ Yes ○ No	
Was	as the cause of the anemia due to bleeding from the gastrointestinal tract?	
0	Yes No	
	Was the last occurrence of gastrointestinal bleeding within the past 2 years?	
	○ Yes ○ No	
	Was there any cancer or malignancy found to be the cause of the bleeding?	
	Yes No	
	Have the symptoms fully resolved and anemia no longer present?	
	○ Yes ○ No	
	Have you had a colonoscopy with abnormal results in the past 2 years?	
	O Yes O No	
	Have you been advised to have a colonoscopy or other testing involving the gastrointestinal tract that has not yet been	completed?
	O Yes O No	
Other	er	
	Explain:	
	<u></u>	
Diabete	tes treated with insulin or requiring hospitalization	
	e indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in t es to diabetes treated with insulin or requiring hospitalization (select all that apply)	ne past 10 years as
Hav	ve you been prescribed Insulin to treat your diabetes?	

Have you been hospitalized in the past 5 years due to diabetes?	
© Yes ◎ No	
Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?	
© Yes ◎ No	
Have you been diagnosed by a member of the medical profession with heart disease, kidney disease, excessive protein or albumin in the	
urine, or blindness?	
© Yes [©] No	
Have you had any limbs amputated due to diabetes or circulatory problems?	
© Yes © No	
Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?	
© Yes © No	
What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?	
◎ 7.0 orless	
© 7.1-9.99	
© 10.0 or higher	
© unknown	
What was your most recent blood sugar test result?	
© Below 145	
© 145 to 220	
Over 220	
Have you been prescribed oral medications or diet to treat your diabetes?	
© Yes ◎ No	
Have you been hospitalized in the past 5 years due to diabetes?	
◯ Yes ◯ No	
Have you ever been diagnosed with a diabetic coma in the past 10 years by a medical professional?	
© Yes [©] No	

	Have you had any limbs amputated due to diabetes or circulatory problems
	O Yes No
	Have you ever required dialysis or been advised by a member of the medical profession that you need dialysis?
	○ Yes ○ No
	What was your most recent Hemoglobain A1c (HGB A1c, glycosylated hemoglobin) test result?
	7.0 or less
	O 7.1 - 9.99
	10.0 or higher
	O unknown
	What was your most recent blood sugar test result?
	© Below 145
	© 145 to 220
Lligh blo	Over 220
Please i	ood pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as
Please i it relate:	ood pressure requiring more than 2 medications or hospitalization
Please i it relates	nood pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply)
Please i it relates	nood pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) In past 6 months have you had a blood pressure reading over 160/100? Yes No
Please i it relates In the	nood pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) In past 6 months have you had a blood pressure reading over 160/100? Yes No
Please i it relates In the Have	nood pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) In past 6 months have you had a blood pressure reading over 160/100? Yes No In past 10 years as the past 6 months have you had a blood pressure reading over 160/100? Yes No In past 10 years as the past
Please i it relates In the	nood pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100?
Please i it relates In the	nood pressure requiring more than 2 medications or hospitalization Indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over 160/100? In past 6 months have you had a blood pressure reading over
Please i it relates In the	noticate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as to high blood pressure requiring more than 2 medications or hospitalization (select all that apply) e past 6 months have you had a blood pressure reading over 160/100? Yes No e you ever been diagnosed with Stroke, Cerebral Vascular Accident (CVA), Transient Ischemic Attack (TIA), Heart Disease, Congestive Heart ure, Peripheral Vascular disease, or disease or disorder of the heart valves? Yes No ou have any cardiac testing or procedures pending or advised to have completed that have not been completed?

	O Yes O No		
Select all which are applicable):			
П	eart attack or any disease or abnormality of the heart or blood vessels.		
	rase indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 ars as it relates to heart attack or disease or abnormality of the heart or blood vessels. (Select all that apply):		
	Heart Attack		
	Stroke or Cerebral Vascular Accident (CVA)		
	Coronary Artery Disease		
	Coronary Bypass surgery, coronary angioplasty, or Stinting of coronary artery or arteries.		
	Congestive Heart Failure		
	Disease of the heart valve or valves		
	Heart Murmur		
	Does your heart murmur cause any restrictions on activity?		
	© Yes ◎ No		
	Have you ever had any blackouts or fainting episodes due to your heart murmur?		
	◎ Yes ◎ No		
	Have you ever been diagnosed by a member of the medical profession with a disease or disorder of the heart valves?		
	O Yes O No		
	Have you been diagnosed with Mitral Valve Prolapse (MVP)?		
	O Yes O No		

within the last 6 months over 6 months ago never had an echocardiogram Have you been advised to have an echocardiogram (ultrasound of heart) that has not yet been completed? Yes No Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed? Yes No Explain: Irregular heartbeat, palpatations, or arrhythmia High Blood Pressure or Hypertension Other Explain: Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease. Cancer (excluding basal and squamous cell skin cancer), leukenia, lymphoma, or any other malignancy. Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex. Nenous system disease. Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply): Dementia or cognitive disease or disorder Huntington's Disease Multiple Sclerosis Stoke or Cerebral Vascular Accident (CVA) Parkinson's Disease Arryotophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease Seizure disorder or epilepsy	0 1111		
enever had an echocardiogram Have you been advised to have an echocardiogram (ultrasound of heart) that has not yet been completed? Yes No Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed? Yes No Explain: Irregular heartbeat, palpatations, or arrhythmia High Blood Pressure or Hyperfension Other Explain: Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease. Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex. Tested positive on an acquired immune deficiency syndrome-related test. Nervous system disorder or disease. Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply): Dementia or cognitive disease or disorder Huntington's Disease Multiple Sclerosis Stroke or Cerebral Vascular Accident (CVA) Parkinson's Disease Amyotophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease	ove.		
Have you been advised to have an echocardiogram (ultrasound of heart) that has not yet been completed? Yes No Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed? Yes No Explain: Irregular heartbeat, palpatations, or arrhythmia High Blood Pressure or Hypertension Other Explain: Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease. Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. Acquired immune deficiency disease or disorder (AIDS), AIDs-Related Complex. Tested positive on an acquired immune deficiency syndrome-related test. Nervous system disorder or disease. Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply): Dementia or cognitive disease Multiple Sclerosis Stroke or Cerebral Vascular Accident (CVA) Parkinson's Disease Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease		· 6 months ago	
Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease. Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex. Tested positive on an acquired immune deficiency syndrome-related test. Nervous system disorder or disease. Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply): □ Dementia or cognitive disease. Multiple Sclerosis Stroke or Cerebral Vascular Accident (CVA) Parisinson's Disease Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease	nev nev	er had an echocardiogram	
Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease. Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex. Tested positive on an acquired immune deficiency syndrome-related test. Nervous system disorder or disease. Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply): □ Dementia or cognitive disease. Multiple Sclerosis Stroke or Cerebral Vascular Accident (CVA) Parisinson's Disease Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease	Have ve	u haan advised to have an echocardingram (ultracound of heart) that hee not yet heen completed?	
Do you have any other cardiac testing or procedures pending or advised to have completed that have not yet been completed? Yes No Explain: Irregular heartbeat, palpatations, or arrhythmia High Blood Pressure or Hypertension Other Explain: Stroke, cerebral vascular accident (CVA), aneurysm, or any peripheral vascular disease. Cancer (excluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. Acquired immune deficiency disease or disorder (AIDS), AIDS-Related Complex. Tested positive on an acquired immune defliciency syndrome-related test. Nervous system disorder or disease. Please indicate all of the following for which you have been diagnosed or treated by a member of the medical profession in the past 10 years as it relates to nervous system disease or disorder. (Select all that apply): Dementia or cognitive disease or disorder Huntington's Disease Multiple Sclerosis Stroke or Cerebral Vascular Accident (CVA) Parkinson's Disease Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease	-		
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 ■ Multiple Sclerosis ■ Stroke or Cerebral Vascular Accident (CVA) ■ Parkinson's Disease ■ Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's Disease 	Cancer (ex Acquired ir Tested pos Nervous sy	cluding basal and squamous cell skin cancer), leukemia, lymphoma, or any other malignancy. nmune deficiency disease or disorder (AIDS), AIDS-Related Complex. sitive on an acquired immune deficiency syndrome-related test. stem disorder or disease. cate all of the following for which you have been diagnosed or treated by a member of the medical profession.	on in the past 10
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	When was your last attack/episode of epilepsy or seizure?
	O -3 years ago
	O 3-7 years ago
	Over 7 years ago
	Are you considered disabled due to seizure disorder or epilepsy?
	○ Yes ○ No
	Is seizure disorder or epilepsy caused by a brain or other nervous system tumor?
	○ Yes ○ No
	Do you have any testing or procedures that have been recommended by a member of the medical profession for seizure disorder or epilepsy
	that has not yet been completed?
	○ Yes ○ No
	Explain:
€ Ha Pa	is the tremor been present for less than 2 years? Yes No is the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no rkinson's disease or other underlying cause?
€ Ha Pa	Yes No Is the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no orkinson's disease or other underlying cause? Yes No
€ Ha Pa	Yes No Is the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no rikinson's disease or other underlying cause? Yes No Do you have any testing or procedures with respect to the tremor that have been recommended by a member of the medical profession that
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€ Ha Pa	Yes No six the tremor been evaluated by a member of the medical profession and determined to be a benign, essential, or physiological tremor with no rkinson's disease or other underlying cause? Yes No Do you have any testing or procedures with respect to the tremor that have been recommended by a member of the medical profession that has not yet been completed?

Quadriplegia or tetraplegia
Paraplegia or Paraparesis
Hemiplegia or Paraparesis
Non-paralyzing injury to spinal cord
□ Spondylosis
Herniated disc or compression of the spinal cord
Other Spinal Cord disease, disorder or injury
Explain:
T T T T T T T T T T T T T T T T T T T
Do you currently use a wheel chair?
O Yes No
Do you currently require the use of narcotics to control pain?
O Yes O No
Do you currently require walking aids?
O Yes No
Are you considered disabled due to the spinal cord injury or disease?
○ Yes ○ No
Tumor of the nervous system or brain
Was the tumor considered cancerous or malignant?
◎ Yes ◎ No
Was the tumor a brain tumor?
○ Yes ○ No
Has the brain tumor been surgically removed?
○ Yes ○ No
○ Yes ○ No Was the brain tumor removed within the past 10 years?
Was the brain tumor removed within the past 10 years?
Was the brain tumor removed within the past 10 years? Pyes No

O Yes No Do you have any completed? Yes No	
	noved d within the past 2 years? neurological testing or procedure that has been recommended by a medical professional that has not yet be
Was the tumor surgically ref Yes No Was the tumor remove Yes No Do you have any completed? Yes No Exp	d within the past 2 years? neurological testing or procedure that has been recommended by a medical professional that has not yet be
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O Yes No Do you have any completed? Yes No Exp	neurological testing or procedure that has been recommended by a medical professional that has not yet be
Do you have any completed? Yes No Exp	
completed? O Yes O No Exp	
	lain:
Ехұ	lain:
	lain:
3	
Bipolar	
Schizophrenia	
Depression	
Have you been hospit:	lized for this condition in the past 5 years?
O Yes O No	
Have you ever attempt	ed suicide?
O Yes O No	
	abled due to this condition?
O Yes O No	
Anxeity	
Have you been hospita	lized for this condition in the past 5 years?
O Yes O No	

Other		
	Explain:	
		÷
☐ Bells Palsy		
Have you be	en diagnosed by a member of the medical profession with Bells Palsy within the past 6 months?	
○ Yes ○	No	
Trigeminal Ne	uralgia	
Have you ha	d surgery for trigeminal neuralgia?	
○ Yes ○	· · ·	
Have	you fully recovered from the surgery?	
© Y	es O No	
Has surgery	been recommended that has not been completed?	
O Yes O	No	
Thoracic Outle	et Syndrome	
Narcolepsy		
Were you firs	st diagnosed by a member of the medical profession with Narcolepsy within the past 2 years?	
O Yes O	No	
Have you ha	d any symptoms of narcolepsy in the past year?	
O Yes O	No	
Other nervous	system disorder or disease	
Expla	uin:	
		A.

☐ Kidney Disease	
Blockage of the renal (kidney) arteries	
Hypertensive renal (kidney) disease	
Cancer of the kidney	
Had dialysis or been advised to have dialysis?	
Kidney failure	
Glomerulonephritis, nephritic or nephrotic syndrome	
Polycystic kidney disease	
Kidney stones	
☐ Kidney infection	
Did your kidney infection occur in the past 3 months?	
© Yes © No	
Have you fully recovered from your kidney infection	
○ Yes ○ No	
Cother Cother	
Explain:	
	^
	v
☐ Hepatitis B or C	
□ Hepatitis A	
Have you fully recovered from Hepatitis A?	
O Yes O No	
Non-viral hepatitis	
□ Enlarged liver	
Cirrhosis of the liver	
Primary Biliary Cirrhosis	

Have you been advised by member of the medical profession that your liver enzymes or liver function tests are abnormal or elevated?
Yes No
Have you been advised by a member of the medial profession that the cause of fatty liver is related to alcohol use?
● Yes ● No
Have you had a liver biopsy or has a liver biopsy been recommended by a member of the medical profession?
Yes No
Have you been diagnosed by a member of the medical profession with Non-Alcoholic Steatohepatitis (NASH)?
O Yes O No
Pancreatitis
Tumor or Cancer of the Pancreas
Crohn's or ulcerative colitis
Do you use steroids or immunosuppressive drugs for treatment?
O Yes No
Have you been hospitalized for Crohn's or ulcerative colitis in the past 5 years?
Yes No
Did you require surgery or have you been advised by a member of the medical profession to have surgery for Crohn's or ulcerative colitis which
has not been performed?
O Yes No
Have you had an attack of Crohn's or ulcerative colitis within the past year?
◎ Yes ◎ No
Does Crohn's or ulcerative colitis limit normal activity or are you considered disabled due to this condition?
O Yes O No
Has a member of the medical profession advised you to have a colonoscopy or other test related to the gastrointestinal tract that has not been
completed?
Yes No

Alzheimer's, schizophrenia, bipolar or mental disorder.	
Please indicate all of the following for which you have been diagnosed of	or treated by a member of the medical profession in the past 10 years as
it relates to alzheimer's, schizophrenia, bipolar or mental disorder (sele	ect all that apply):
Alzheimer's	
Schizophrenia	
☐ Bipolar	
Attempted Suicide	
Depression	
Have you been hospitalized for this condition in the past 5 years?	
○ Yes ○ No	
Have you ever attempted suicide?	
○ Yes ○ No	
Are you considered disabled due to this condition?	
O Yes O No	
Anxiety	
Have you been hospitalized for this condition in the past 5 years?	
○ Yes ○ No	
Have you ever attempted suicide?	
O Yes O No	
Are you considered disabled due to this condition?	
Other	
Explain:	
	<u>~</u>

CONTINUE

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If med question decline:







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We're sorry, based on the information provided, the application process can not be completed online. If you would like to submit an application for consideration, please click the "Print Application" below, complete the application, make sure it's signed by the person to be covered, and mail it to:

American National Life Insurance Company P.O. Box 696700 San Antonio, TX 78269

Note: You MUST have Adobe Acrobat Reader 5.0 or higher installed on your computer to view the online application. You may click on the "Get Acrobat Reader" logo to obtain

Click here to "Print your application".

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If decline -







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2 APPLY FOR INSTANT COVERAGE



PAYMENT OPTIONS

Application process options

Without the required acceptance of the Notice of Information Practices and Electronic Consent, we cannot continue online processing of your application.

- $\ igodots$ Option 1: Continue with electronic process.
- Option 2: I would prefer to print my application, sign it, and send it to American National Insurance Company. I understand that, if approved, I will receive my policy in the mail and that I must remit my initial premium before any insurance will go into effect.
- Option 3: Please discontinue processing my application. I understand that I may return at a future date and apply again but I will have to complete a new application at that time.



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Ex opt 1 – go to Disclosure Page

Ex opt 2 –







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Important Reminder!

Processing can't begin until we receive your signed application.

Note: You MUST have Adobe Acrobat Reader® 5.0 or higher installed on your computer to view the online application. You may click here to obtain a FREE copy.

Please click here to see your application. Then review, print, sign, date and mail it to American National Insurance Company at the following address:

American National Insurance Company P.O. BOX 696700 San Antonio, TX 78269

Your application, will be processed immediately upon receipt and, once approved, your policy will be mailed. The next screen will present the application as you've completed it to this point. Please don't delay - print and mail your application today! Thank you for considering American National Insurance Company for your life insurance needs. We look forward to receiving your application soon.

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Ex opt 3 -







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PAYMENT OPTIONS

Thank You!

Thank you for considering American National Insurance Company for your life insurance needs. We're sorry we were unable to meet your needs at this time but we hope you will return to our site the next time you consider providing financial security for your family.

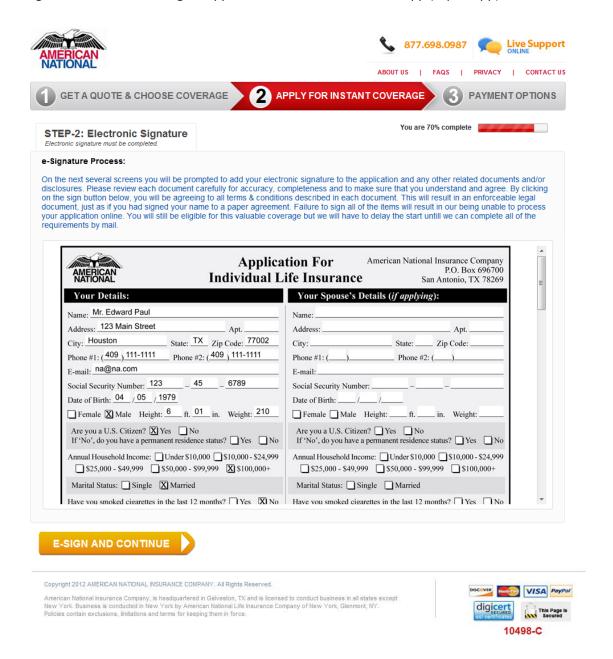
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If agree from Disclosure Page – App is scrollable to review entire app (top of app)



Bottom of app... cont...



Your Spouse's Signature: X

Date: X

E-SIGN AND CONTINUE

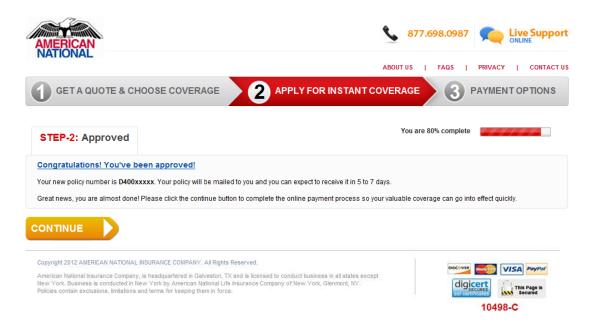
Date: X 01 / 01 / 2012

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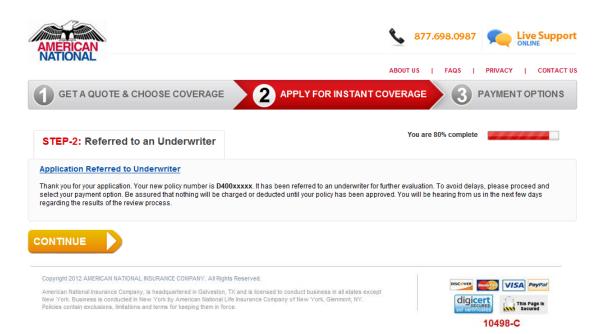
American National Insurance Company, is headquartered in Galveston, TX and is licensed to conduct business in all states except New York. Business is conducted in New York by American National Life Insurance Company of New York, Glenmont, NY. Policies contain exclusions, limitations and terms for keeping them in force.



Approve -



RTU



AMEDICANI	tion For American National Insurance Company P.O. Box 696700 San Antonio, TX 78269
Your Details:	Your Spouse's Details (if applying):
Name: Mr. Edward Paul	Name:
Address: 123 Main Street Apt	Address: Apt
City: Houston State: TX Zip Code: 77002	City: State: Zip Code:
Phone #1: (409) 111-1111 Phone #2: (409) 111-1111	Phone #1: () Phone #2: ()
E-mail: na@na.com	E-mail:
Social Security Number: 123 45 6789	Social Security Number:
Date of Birth: 04 / 05 / 1979	Date of Birth://
Female Male Height: 6 ft. 01 in. Weight: 210	Female Male Height: ft. in. Weight:
Are you a U.S. Citizen? X Yes No If 'No', do you have a permanent residence status? Yes No	Are you a U.S. Citizen? Yes No If 'No', do you have a permanent residence status? Yes No
Annual Household Income: Under \$10,000 S10,000 - \$24,999 \$25,000 - \$49,999 \$50,000 - \$99,999 \$\$100,000+	Annual Household Income: Under \$10,000 \ \$10,000 - \$24,999 \ \$25,000 - \$49,999 \ \$50,000 - \$99,999 \ \$100,000+
Marital Status: Single Married	Marital Status: Single Married
Have you smoked cigarettes in the last 12 months? Tyes X No	Have you smoked cigarettes in the last 12 months? Yes No
Occupation: franchise owner	Occupation:
Your Amount of Coverage & Beneficiary:	Your Spouse's Coverage & Beneficiary:
Plan: BudgetGuard 7 Year Term	Plan:
Amount (choose one): Sxxx,xxx Sxxxxx	Amount (choose one): \$\sum \\$xxx,xxx \\$xxx,xxx
\$xxx,xxx	Sxxx,xxx Other: \$
Beneficiary: Ruth Paul	Beneficiary:
Date of Birth: 03 / 10 / 1980 Relationship: Spouse Automatic Premium Loan Provision Requested? Yes X No	Date of Birth: / / Relationship: Automatic Premium Loan Provision Requested? ☐ Yes ☐ No
IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☒ No	IMPORTANT: Do you intend to replace, discontinue, or change any existing life insurance policy? ☐ Yes ☐ No
If 'Yes', name of company and policy number(s) if available:	If 'Yes', name of company and policy number(s) if available:
Your Health:	Your Spouse's Health (if applying):
 Within the past 10 years, have you been diagnosed or treated by a m of the heart or blood vessels, stroke, cerebral vascular accident (CV squamous cell skin cancer), leukemia, lymphoma, malignancy, nervo 	ember of the medical profession for: heart attack, disease or abnormality /A), aneurysm, peripheral vascular disease, cancer (excluding basal and ous system disease or disorder, hepatitis C, kidney, liver, pancreas disease r as having an acquired immune deficiency disease or disorder (AIDS),
You Yes X No	Your Spouse Yes No
10498-AR continued o	on back

	Your Health:	Your Spouse's Health (if applying):
	attack (TIA), hospitalized for depression or attempted suicide, diag	member of the medical profession for a seizure or transient ischemic gnosed or treated by a member of the medical profession or received se, convicted of driving while intoxicated (DWI) or driving under the Your Spouse Yes No
3.	are you currently admitted to or confined to a hospital, mental institute care or need assistance with eating, bathing or dressing?	titution, nursing home, assisted living center or receiving home health
	You Yes X No	Your Spouse Yes No
4.	Within the past 10 years, have you been diagnosed or treated by a member of the medical profession for: musculoskeletal disorder, lupus, connective tissue disease, lung disease or disorder, clotting or bleeding disorder, anemia or blood disease, diabetes treated with insulin or requiring hospitalization, high blood pressure requiring more than 2 medications or hospitalization? If "Yes", provide details below (dates of treatment, test results, diagnoses, medications, etc.)	
	You Yes X No Details:	Your Spouse Yes No Details:
		·
5.		ne medical profession to get specified medical care which has not yet tion, surgery or diagnostic test, except those tests related to the Human elow: Your Spouse Yes No Details:
	If you have more details, please inclu	de them on a separate sheet of paper
		ue mem on a separate succe of pape.
	Valle Paviment — choose one:	
	Your Payment — choose one: we authorize the collection of premiums for the policy or policies as	; follows
I/v	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d	ecount.
I/v 1.	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a	deposit slip when providing savings account.)
I/v 1.	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d	deposit slip when providing savings account.)
I/v 1. 2. 3.	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d Charge monthly premiums to my: Visa MasterCard	count. deposit slip when providing savings account.) Discover (Account Number) (Exp. Date)
I/v 1. 2. 3. I to the iss be on ha is de thir wir bu Co I a ph face (N. he co I a co	we authorize the collection of premiums for the policy or policies as Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a d Charge monthly premiums to my: Visa MasterCard Bill me/us. (Send no money now.)	count. deposit slip when providing savings account.) Discover (Account Number) (Exp. Date)
I/v 1. 2. 3. I to the issisted this will but Cool I a ph face (Michael and II).	Automatic monthly deductions from my checking or savings a (Enclose a voided check when providing checking account and a did the Charge monthly premiums to my: Visa MasterCard Bill me/us. (Send no money now.) Agreements and Your Authorization to Obtain, Release understand and agree: that the answers in this application are, the best of my knowledge and belief, complete and true; that e answers will be relied upon to determine if coverage will be sued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or missions may cause the policy to be void; that the Company will are no liability until a policy is issued and the first premium due paid in full while I am alive and in the same health condition as escribed above; that if my spouse and I request life insurance on is application that my personal financial and health information ritten on it will be made part of the policy issued to not only me at also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application. But also my spouse; and that if I do not agree, I may contact the company and receive a separate application.	Discover (Account Number) (Exp. Date) ase and Disclose Medical Information: or to any agent or agency acting on its behalf or to its reinsurer(s). I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand: that the Company will use this information to determine my eligibility for life insurance and the premium amount; that I may refuse to sign this authorization and that my refusal will affect my ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address. • I acknowledge receiving the Exchange of Information Notice. • Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement

<u>Screen appendix A – Call Center Path</u>

Exchange of Information, Medical Information Bureau, Inc. Pre-notifications, Fair Credit Reporting Act and USA Patriot Act Notices: -

Exchange of Information Notice

We are required to provide the following disclosures to you: Medical Information Bureau, Inc. (MIB) Pre-Notification Information regarding your insurability will be treated as confidential. American National Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. American National Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Pre-notification

We may obtain an investigative consumer report in connection with your application. This report may contain information about your character, general reputation, personal characteristics or mode of living gathered from personal interviews with persons who may be acquainted with you. The information is kept confidential. You have the right to additional information about the nature and scope of the investigation provided you submit your request in writing within a reasonable period of time. We will inform you whether an investigative consumer report was requested and provide you with contact information for the agency preparing the report. By contacting the agency and providing proper identification, you may inspect or receive a copy of such report. A summary of your rights may be found on the Internet at www.ftc.gov/credit.

USA Patriot Act Notice

The USA Patriot Act requires that we establish an Anti-Money Laundering ('AML') Program, notify customers that we must verify the identity of the owner(s) of our contracts that have cash value, and collect information sufficient to verify identity. Failure to provide us identification information may result in the delay of issuance of coverage and may result in a decision not to accept your business.

Consent For Use Of Electronic Signatures and Records

American National Insurance Company is required by law to provide you with certain disclosures and information about your life insurance application. This part of the notice requires you to consent to the use of electronic signatures in connection with your application. This consent will allow the representative to electronically sign on your behalf, the application documents for which you have just provided information. Even if you consent to use electronic signatures, paper copies of the application documents will be sent to you with your policy for your review.

Application Disclosure

You understand and agree: that the answers in this application are, to the best of your knowledge and belief, complete and true; that the answers will be relied upon to determine if coverage will be issued and the amount of premium that will be charged and will become a part of the Policy; that any material misstatement or omissions may cause the policy to be void; that the Company will have no liability

until a policy is issued and the first premium due is paid in full while you are alive and in the same health condition as described above; that if your spouse and you request life insurance on this application that your personal financial and health information written on it will be made part of the policy issued to not only you but also your spouse; and that if you do not agree, you may contact the Company and receive a separate application.

You authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, the Medical Information Bureau (MIB) or other organization that has any records concerning health or medical care, advice or treatment provided to you to give any such information to American National Insurance Company, or to any agent or agency acting on its behalf or to its reinsurer(s). You authorize the Company, or its reinsurers, to make a brief report of your personal health information to MIB. You understand: that the Company will use this information to determine your eligibility for life insurance and the premium amount; that you may refuse to sign this authorization and that your refusal will affect your ability to obtain insurance; that such information may be subject to redisclosure and if so may no longer be protected by federal privacy law; that this authorization shall be valid for 24 months from the date signed and a copy will be as valid as the original; and that you have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance thereon, by sending written notice to: the Company at the above address.

You acknowledge receiving the Exchange of Information Notice.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Appendix C -

Website template subject to change (indicated in red boxes below – header and footer):



ANICO Direct Processes:

As a Direct Marketing division, we send Direct Marketing solicitations to perspective clients through direct mail and electronic media (Email, Banners, SEO, SEM, Aggregators and Call Centers).

Electronic Media process:

- The primary path for the customer is to click on a link within the appropriate media and to enter ANICO Direct's website where if they make a decision to receive a rate quote they proceed to the customer portal.
- The secondary path for the customer is to call on the phone number that is provided within the email or website. There, they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

Direct Mail process:

- The primary path for the customer is to fill out the application and send it to American National for processing.
- As a secondary path, the customer is provided with a URL within the letter; the URL allows the
 customer to go to ANICO Direct's website where if they make a decision to receive a rate quote,
 they proceed to the customer portal.
- An additional secondary path is that the customer is also provided with the call center phone number, where they can speak to a live person to discuss their needs and complete the process online with a licensed agent.

The tools used to complete the process online is either a Call Center portal (completed by our call center agents) or the Customer path (completed by the customer applying for the product).

Call Center portal:

- When a customer calls our call center, we have the ability to help them by taking them through the Path which we refer to as the call center portal. In order to write the business for the customer, the agent must be licensed in that state. Within the portal, there is a validation against the licensing system to validate the licensing.
- The process, where necessary, is tailored for the agent to read the disclosures on the screen as a script, with the customers consent to complete the process on their behalf.
- The process also has embedded recordings, since disclosures can be state specific, the portal
 uses the insured state to queue the appropriate recording to ensure consistency with the
 disclosures.
- Once the questions and disclosures are completed, the application is generated in Silanes for an
 e-signature process. The e-signature process is approved by the customer and recorded for
 validation with a process called CVR (Continuous Voice Recording). The e-signature process is a
 secured signature process confirming acknowledgement of the application.
- CVR records the entire conversation through a vendor called Verint. The database is completely secured with read-only access to the data base to pull the recordings for review. In order to easily identify the recording, the agent "tags" the conversation with software called Taglt. The policy number is entered into Taglt to identify the recording.

Customer portal:

- They potential customer enters data into a series of data fields, selects the product they are
 interested in and are asked a series of medical questions. They are then presented with
 disclosures to agree to. Their responses to the fields and medical questions are saved to a
 database that is later used to populate the application for signature.
- Once the questions and disclosures have been completed, the application is generated in Silanes
 for an e-signature process. The e-signature process is approved and completed by the customer.
 All policies written through the tools above are sent to the administration system for processing.

Administration:

• Once the case is assigned a policy number and signed, the case is sent to the Administration system that will process the application. The final disposition of the case is determined and correspondence is sent from that system. The final correspondence will either be a bill and policy or a decline letter.